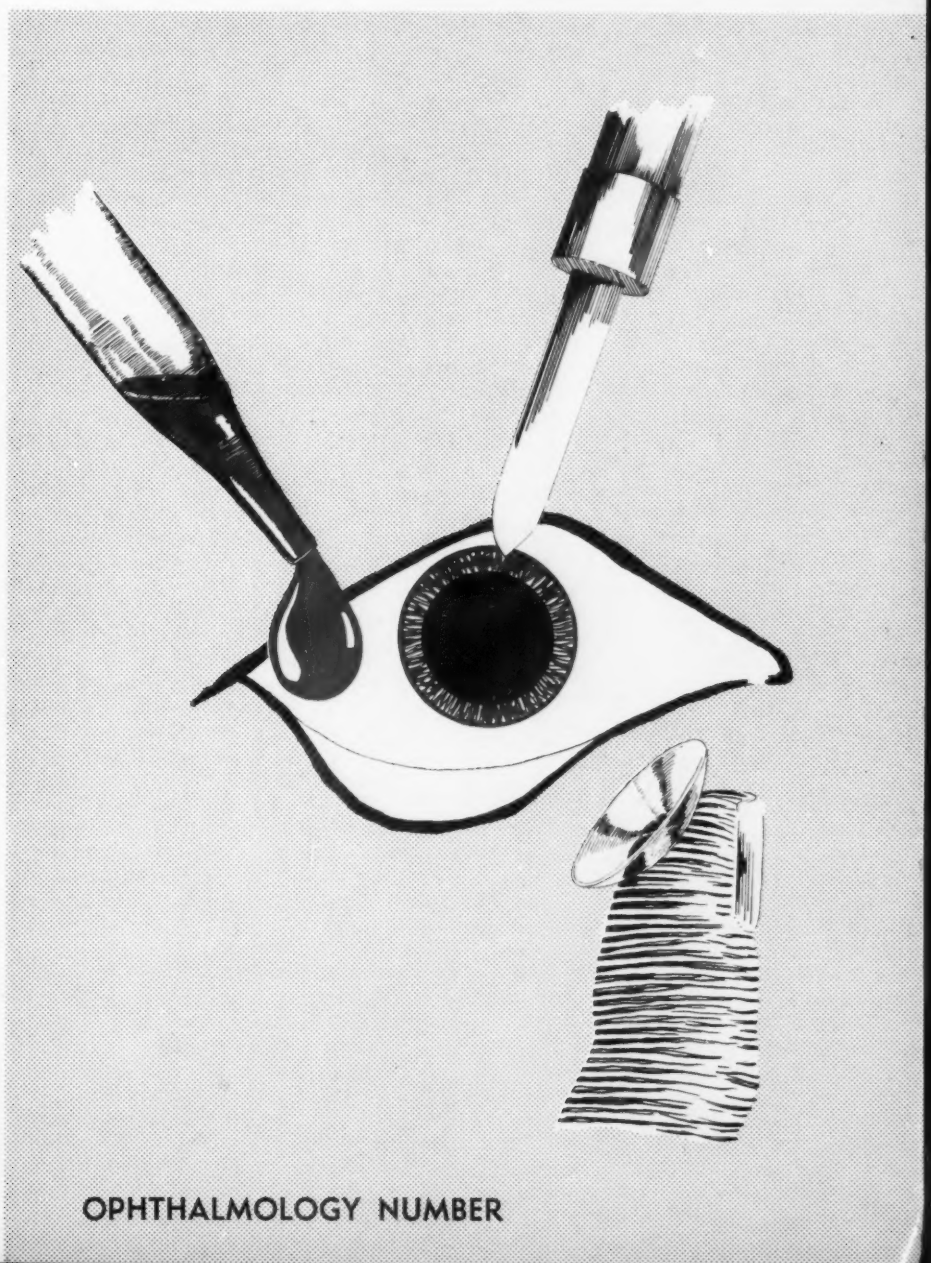
the Journal
MICHIGAN
STATE MEDICAL SOCIETY
AUGUST 1961 • VOLUME 60 • NUMBER 8



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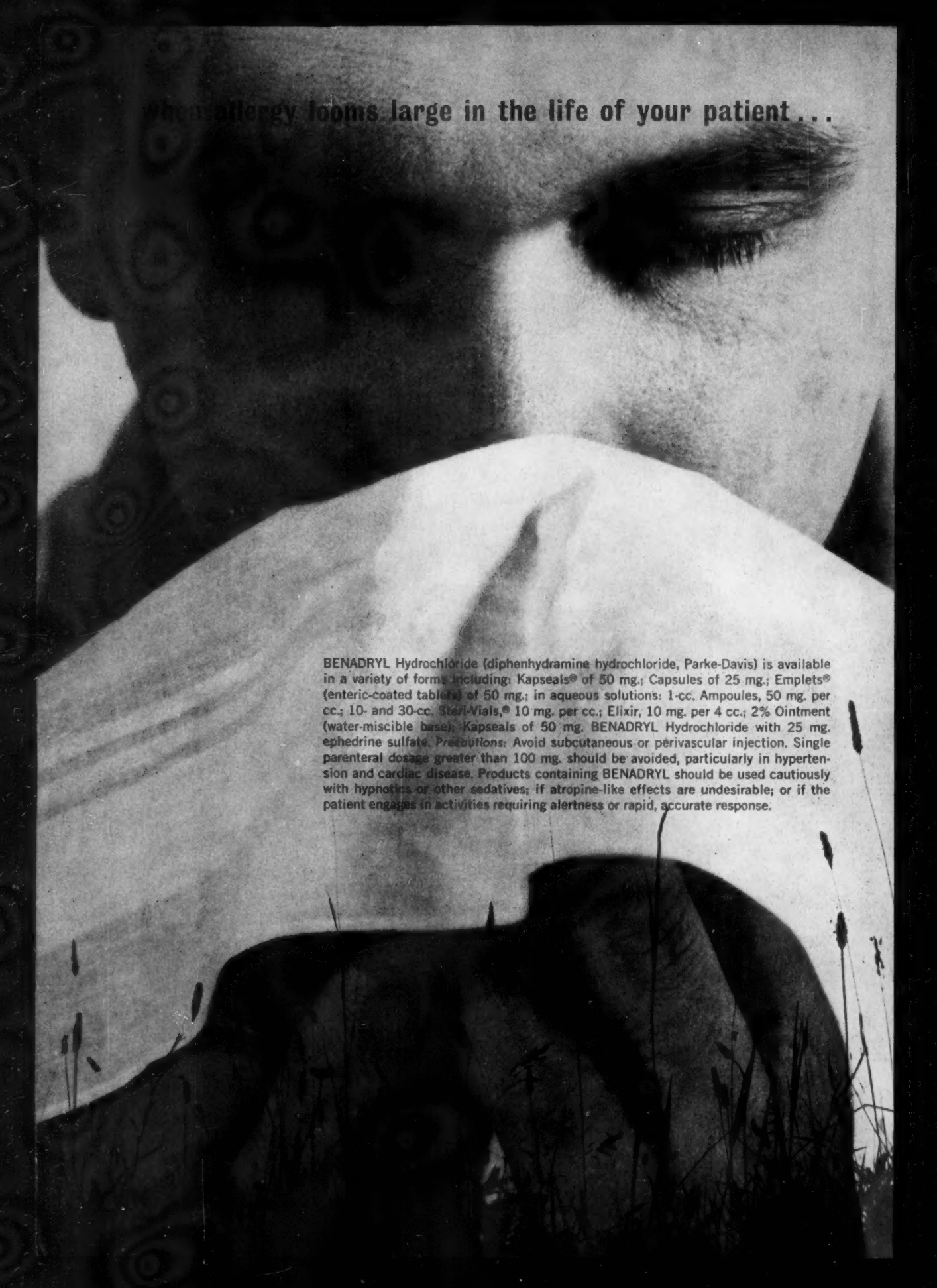

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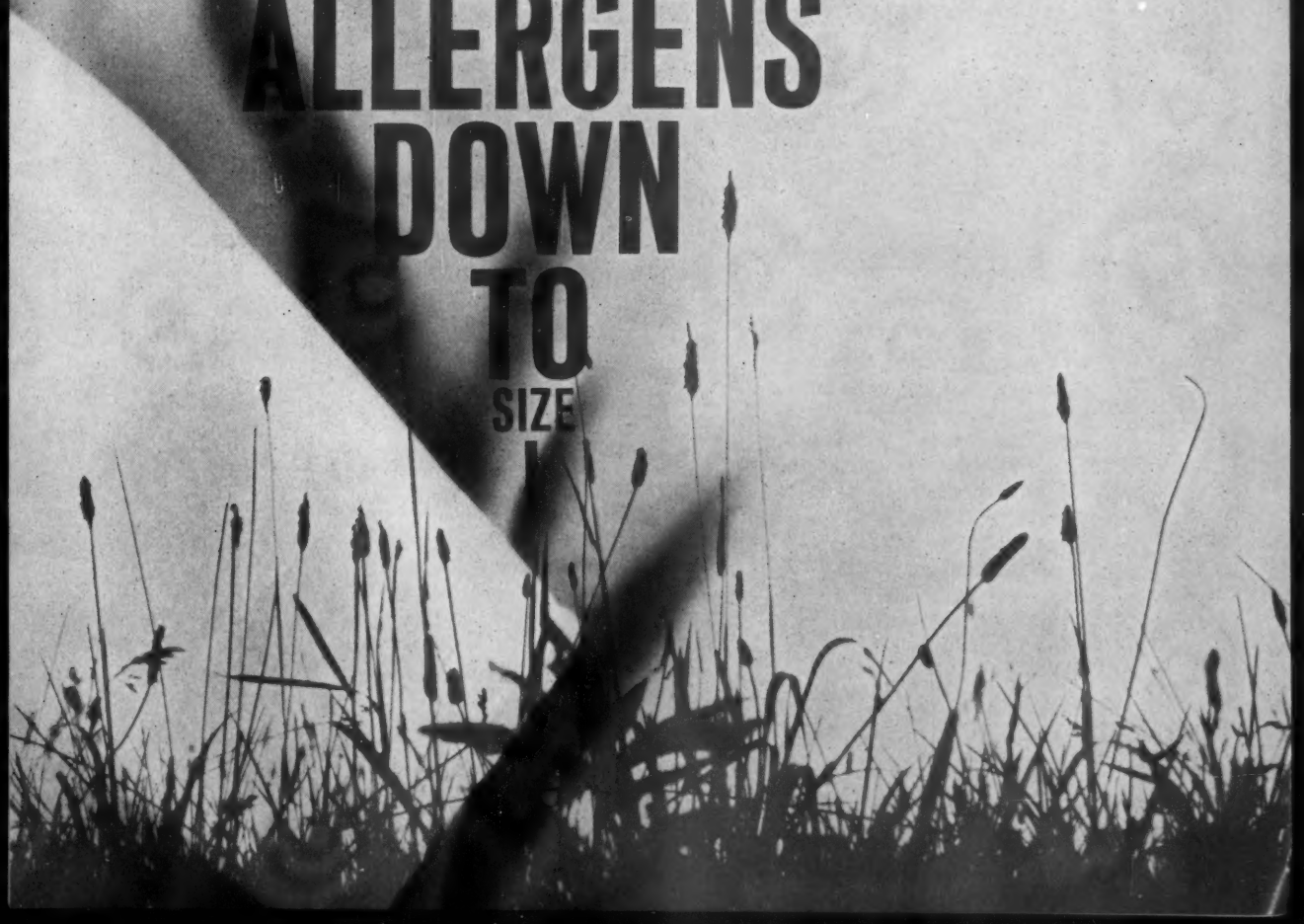

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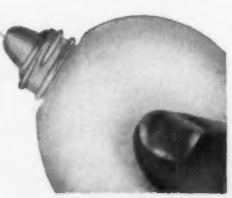

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the Journal MICHIGAN
STATE MEDICAL SOCIETY

Volume 60 Number 8

August, 1961

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 120 W. Saginaw Street, East Lansing, Michigan. Telephone 337-1351.

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THE COVER

THE JOURNAL, this month, contains special articles about Ophthalmology. The cover art ties in with both an article and an editorial about contact lenses.

IN THIS ISSUE

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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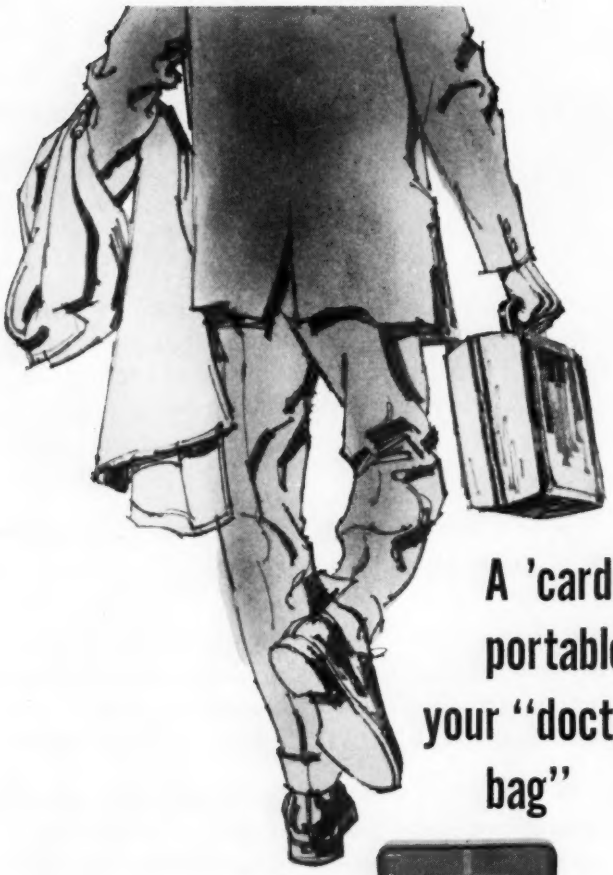

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Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. 38:738 (Sept.) 1959.

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President's Page

HI, YOUNG FELLOW!

Kenneth N. Hudson

President
Michigan State Medical Society

I use that salutation for a distinct purpose. Regardless of your age, I do consider you a "young fellow."

I would explain, by quoting some recent research:

> "Older persons tend to respond to inner rather than outer stimuli, to withdraw emotional investments, to give up self-assertiveness, and to avoid rather than to embrace challenge."

Now, do you agree that you are a "young fellow," ready to deal with complicated, challenging or conflictful situations? You have a tendency to perceive vigorous and assertive activity, don't you? And you have what the study calls lots of "ego energy," right?

> (You may want to read about this interesting research project reported by J. L. Rosen, and B. L. Newgarten in "Journal of Gerontology," Vol. 15, No. 1)

Well, to get to the point. As a "young person" with energy, determination and spirit, you will want to attend the 1961 MSMS Annual Session at Grand Rapids, September 24-29. You will have opportunities there for new experiences, new knowledge, new friendships. There will be challenges—but remember the research study has proven that young men seek such activities.

So, "young fellow," we'll see you in Grand Rapids!

MSMS Says King Bill "Totally Unnecessary"

Washington, D. C.—The House Ways and Means Committee heard a Michigan contention that the King Bill is unnecessary and that the Kerr-Mills Law is meeting the health care needs of the aged.

"The Michigan State Medical Society commends the House Ways and Means Committee for its rejection last year of the social security approach and its approval instead of the Kerr-Mills program of federal-state grants to aid those older citizens who may need assistance in meeting their health care costs."

That statement was made July 27 before the House Committee's hearing on the King Bill (H.R. 4222) by Otto K. Engelke, M.D., president-elect of the Michigan State Medical Society.

* * *

"MICHIGAN HAS DEVELOPED and is improving its Medical Aid for the Aged program under the Mills Law. The Mills Law will do the job," stressed Dr. Engelke of Ann Arbor.

"The Michigan State Medical Society actively endorsed the original Michigan Medical Aid to the Aged program and wholeheartedly supported the MAA liberalization approved this spring by the Michigan Legislature and Governor," Dr. Engelke reported. He observed, "The Michigan application of the Mills Law and other present programs providing medical aid to the aged are designed to give maximum help to those who need it."

Dr. Engelke requested that the House Committee refuse to recommend the King Bill. "The King Bill is totally unnecessary and can lead only to greater problems than now exist," he said.

* * *

"MICHIGAN PHYSICIANS FIRMLY believe that Congress should again reject the social security approach to providing health care for the aged," said Dr. Engelke, a teacher in the University of Michigan school of public health and the health officer of Washtenaw County.

"Michigan doctors are convinced that the King approach is socialized or nationalized medicine, and that stopping the nationalization of medicine once it has started is like unscrambling eggs."

The 10-point positive program of the Michigan State Medical Society to better serve Michigan residents was detailed by Doctor Engelke before the House Committee.

The speaker stressed that "Michigan doctors of medicine have long been active in forming solutions to the problem which the Committee faces. We shall continue to provide the world's highest quality of medical care to all of Michigan's residents and shall assist all those who need help in meeting the cost of medical care."

The Michigan State Medical Society was one of seven state medical associations that testified against the King Bill, along with the American Medical Association and many national, civic, farm and business organizations.

Hospital Features Beaumont Plaque

The newest development in the Beaumont lore is the presentation of a bas-relief plaque of William Beaumont, M.D., to the Beaumont Hospital by the Oakland County Medical Society. And thanks to the

generosity of friends located in Oakland County, a copy will be made for the Beaumont memorial at Mackinac Island.

The artist, Marshall Fredericks, depicts the strong character and rugged individuality of the doctor. He also chose to show Doctor Beaumont in civilian dress rather than in uniform. The plaque credits the doctor as "Pioneer in Gastric Physiology."

In the article about the plaque in the June issue of the Oakland County Medical Society Bulletin, writer Charles Paul Barker, M.D., pointed out "The work of Dr. Beaumont becomes all the more remarkable when one remembers that such vital medical discoveries resulted from the work of an individual doctor with an individual patient. Viewed in this light, we see the bond between Dr. Beaumont and his patient, Alexis St. Martin, as a magnificent tribute to the unencumbered doctor-patient relationship."

Council Voices Thanks For Checks, Flowers

Two checks in the amount of $100 each have been accepted by The MSMS Council for the new MSMS headquarters from the Clinton County Medical Society and the Oakland County Medical Society.

Most appreciative of the contributions, The Council ordered that recognition be given in THE JOURNAL.

The Council asked also that the names of the persons and organizations presenting flowers for the dedication program be printed.

Beautiful flowers for the dedication were received from the following:

Calhoun County Medical Society, Genesee County Medical Society, Kalamazoo Academy of Medicine, Mecosta-Osceola-Lake County Medical Society, St. Joseph County Medical Society, Washtenaw County Medical Society;

Michigan State Board of Registration in Medicine, Michigan State Grange, Michigan State Podiatry Assoication, State Bar of Michigan;

Los Angeles Dental Society, Oklahoma State Medical Association, State Medical Society of Wisconsin;

Bruce Publishing Company, St. Paul, Minnesota, James Gerity, Jr., Adrian, Michigan, Mead Johnson & Company, Evansville, Indiana;

Belen's Flowers, Lansing, College Drug, East Lansing, Granger Brothers Construction Company, Lansing, Hasselbring Company, Lansing;

Norm Kesel, Florist, East Lansing, Lansing General Hospital, Michigan National Bank, Lansing, W. A. Pomeroy and Associates, Inc., Lansing, Silver Lead Paint Company, Lansing, The Michigan Company, Lansing;

From Dr. Johnson's office personnel—Mrs. Florence Morey, Mrs. Irita Nimphie, Mrs. Vivian Worthington.

Pick Kalamazoo Doctor As Biddle Lecturer

Homer H. Stryker, M.D., Kalamazoo, has been selected to present the Biddle Lecture at the 1961 MSMS Annual Session, at the State Society Dinner Dance, September 28. Highly recommended by many as a speaker, Doctor Stryker will entertain with his dead-pan, witty comments.

This will be the first time that the Biddle Lecture has been presented at the Dinner Dance. The program for the Dinner Dance was altered last year and is currently undergoing further experimentation.

Doctor Stryker reports that his address will be entitled, "So You Want To Go Into Business."

* * *

A NATIVE OF Michigan, he received his medical education and postgraduate training at the University of Michigan and the University Hospital. He practices orthopedic surgery in Kalamazoo and is chief of orthopedic service at the Borgess Hospital of that city.

His hobby shop in the basement of the hospital has grown into the Orthopedic Frame Company with 65 employees. Doctor Stryker has designed several pieces of orthopedic and hospital equipment.

* * *

THE MSMS ANNUAL BANQUET also will highlight three acts of professional entertainment of top-notch calibre. Coming from Chicago to perform and amuse will be Frank Ross, internationally-known comedian who has appeared on the Ed Sullivan and Jack Paar shows; the Carvelares, a fast comedy act, and also Carl and Arlene, pantomime artists.

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

Sept. 24-26	MSMS House of Delegates	Pantlind Hotel, Grand Rapids
Sept. 27-28	Michigan State Medical Assistants Society	Occidental Hotel, Muskegon
Sept. 27-28	Woman's Auxiliary to MSMS	Pantlind Hotel, Grand Rapids
Sept. 27-29	MSMS Annual Scientific Session	Pantlind Hotel and Civic Center, Grand Rapids
Oct. 5	Gastroenterology Clinical Conference	Bronson Hospital, Kalamazoo
Oct. 19	Calhoun County Clinic Day	Battle Creek
Oct. 20-21	U-M Doctors' Day	Ann Arbor

"State Society Dinner Dance" Thursday, September 28, 1961 Pantlind Hotel, Grand Rapids

Homer H. Stryker, M.D.

A highlight of the evening will be a witty address by Homer H. Stryker, M.D., Kalamazoo, who is known for his dead-pan humor. It will be a full evening of fun—preprandials, an excellent dinner, an entertaining program, dancing, and a stellar floor show. Food, Fun and Fellowship.

Plan Now to Enjoy This Delightful Event

ALL MSMS members and their ladies are invited to the "State Society Dinner Dance" for an evening of fun and merriment. Also attending this colorful social event will be the Annual Session exhibitors. The tickets will be limited, so circle your calendar now. An advance reservation form will be mailed to you soon.

Seek Entries in Annual Session Art Exhibit

Plans have been completed for the Annual Session Art Exhibit to be conducted by the Woman's Auxiliary to MSMS for members of both the Auxiliary and MSMS.

The entry procedure is an easy one—all that interested members must do is to take their art work with them to Grand Rapids for the Annual Session and register it then with the Auxiliary committee before noon, September 25.

The following entry regulations are outlined by Mrs. Robert W. Emerick, of Fremont, chairman for the interesting project:

* * *

ALL WORK MUST BE completely original and entirely by the artist submitting it. Each entrant is limited to four entries which may be in one class or any combination of classes.

Oil paintings must be suitably framed. Watercolors, drawings and prints must be matted and/or framed. All framed entries must be equipped with eyelets and wire suitable for hanging. Entries must be brought in by hand. Usual care will be exercised in handling all entries, but we cannot assume liability for accidents in handling, breakage, or loss by theft. Entries will not be insured. Insurance, if desired, should be carried by the exhibitor.

* * *

ENTRIES WILL BE RECEIVED Sunday, September 24, from 1:30-4:30 p.m., and Monday, September 25, from 9-12 noon, on the mezzanine of the Pantlind Hotel.

The action of the Juror will be considered final in both entries accepted and award designation. Juror of Selection and Award: Richard Yonkers, Director, Hackley Art Gallery, Muskegon. The exhibit sponsors assume the privilege of photographing for publicity any work submitted.

Artist must firmly attach to the back of each entry a label giving the following information:

Name .....
Address .....
City .....
Title .....
Medium .....

Awards:

Class I. Painting, including oil, encaustic lacquer, polymer, etc.

Class II. Painting, including watercolor, casein, tempera, gouache.

Class III. Sculpture, including wood, stone, ceramic, metal.

Class IV. Ceramics.

Class V. Drawing and graphic art, including all print techniques.

Class VI. Three dimensional design: weaving, jewelry, metal work, woodcarving.

The exhibit will open Tuesday, September 25, at 11 a.m.

* * *

ALL ENTRIES MUST REMAIN on display until 12 noon, Thursday, September 28. They will be stored at owner's expense if not picked up following the close of the Annual Session. Any additional information may be secured from the chairman of the Art Exhibit: Mrs. Robert W. Emerick, 3947 Shorewood Drive, Fremont.

Journal Article Popular

The New York State Department of Social Welfare's Commission for the Blind reported recently to MSMS that an article reprinted from THE JOURNAL MSMS has proven very popular. The request to further reproduce the article by R. T. Blackhurst, M.D., Midland, which appeared in 1957 in THE JOURNAL MSMS, was sought because—"We are receiving a continuing flow of requests for this article." The New York agency proposes to distribute the article to parents through schools and nursing groups.

Fight on Quacks

Question: What does the AMA consider as its second biggest accomplishment to date?

Answer: Its relentless fight against quacks and charlatans.

* * *

The men of vision, who founded the AMA, centered their attention on the brisk traffic in secret remedies.

To this day, the AMA, through its Bureau of Investigation, takes a lively interest in running down pernicious nostrums and worthless patent medicines for which the public each year squanders millions. It was this Bureau, founded in 1906, that gave the AMA stature with the public.

The Bureau conducts original investigations. It receives information from federal sources such as the Food and Drug Administration, Post Office Department, and Federal Trade Commission.

The Bureau, which receives thousands of inquiries every year, does not itself prosecute quacks, but it frequently provides the necessary evidence that leads to conviction.

in strains or sprains

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buccal tablets

can make a difference to your patient/ reduce recovery time/add comfort to convalescence

VARIDASE stimulates early fibrinolysis to reduce inflammation, swelling and pain. Natural regenerative factors penetrate the site to accelerate healing. A faster return to functional ability follows a more comfortable convalescence—a world of difference to your patient.

Precautions: VARIDASE has no adverse effect on normal blood clotting. Care should be taken in patients on anticoagulants or with a deficient coagulation mechanism. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with antibiotics.

Dosage: One buccal tablet four times daily usually for five days. To facilitate absorption, patient should delay swallowing saliva.

Supplied: Each tablet contains 10,000 Units Streptokinase, 2,500 Units Streptodornase. Boxes of 24 and 100 Tablets.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

HIGHLIGHTS of The Council

Meeting of June 3, 1961

- MSMS headquarters. O. B. McGillicuddy, M.D., Chairman of the Finance Committee, reported on MSMS building boiler insurance and on contract for maintenance of Honeywell controls; also that the former MSMS building at 606 Townsend in Lansing has been sold for cash.

  A house committee composed of staff personnel, to superintend details of maintenance, has been appointed with K. H. Johnson, M.D., as advisor.
- Committee reports. The following were given consideration: Mental Health Committee, meetings of March 2 and of April 26; Tuberculosis Control Committee, March 1; Disaster Medical Care Committee, March 7; Geriatrics Committee, March 10; Occupational Medicine Committee, March 10 and May 12; Legal Affairs Committee, March 16; Medical Care Insurance Committee, April 5 and May 10; Committee on Insurance, April 12; Educational Liaison Committee, April 24; Rheumatic Fever Control Committee, April 26; Medical Care Study Committee, May 3 and May 24 (considered the U-M Study of Hospital and Medical Economics—the McNerney Report); Maternal Health Committee, May 11; Vocational Rehabilitation Committee, May 11; Public Health Committee, May 17; Committee to Study Problems of Emergency Care in Hospitals, May 23; Advisory Committee to Michigan State Medical Assistants Society, March 9; Permanent Conference Committee, May 24; and the Finance Committee of The Council, June 3.
- Harold F. Falls, M.D., was appointed MSMS representative to the Governor's Commission on Prepaid Hospital Plans, with O. K. Engelke, M.D., of Ann Arbor as alternate.
- Committees for the 1962 Michigan Clinical Institute, appointed by Council Chairman H. J. Meier, M.D., of Coldwater, were presented to The Council and approved.
- Development of an MSMS statement of policy re podiatry was discussed; when drafted, this statement is to be sent to the orthopeadic societies of Michigan for perusal before final presentation to the MSMS Council.
- Dedication of new building, June 4. President Johnson reviewed plans for the ceremonies in connection with the dedication at which W. S. Jones, M.D., of Menominee is to be General Chairman.
- Report on annual visit to Washington, D. C., to interview U. S. Senators and Congressmen from Michigan was accepted with thanks.
- Report of Michigan Health Conference at Flint, May 23-25 was reported by K. H. Johnson, M.D.; The Council placed on its minutes a vote of appreciation to the Michigan Health Council in recognition of its fine work, especially to Conference Chairman H. A. Towsley, M.D., of Ann Arbor.
- O. K. Engelke, M.D., MSMS President-Elect, presented a list of MSMS committee appointments for the Society year 1961-1962 which was approved. President-Elect Engelke also reported on the AMA Workshop on Home Care, held in Chicago, May 24-26, which report was received with thanks.
- The offer of Parke-Davis & Co. of Detroit to display its 30 paintings on "The History of Medicine" at the MSMS Annual Session in Grand Rapids was accepted with gratitude.
- Speaker J. J. Lightbody, M.D., of Detroit reported on meetings of House of Delegates committees and announced the appointment of the new Ways and Means Reference Committee of The House, to be Chaired by Arthur W. Strom, M.D., of Hillsdale; he also reported on the four regional Legislative Conferences, authorized by the House of Delegates at its special session of April 16; Doctor Lightbody also stated that a reception in the new MSMS headquarters building in East Lansing was being arranged for Delegates and Alternate Delegates on Sunday, September 24 between 1:00 and 5:00 p.m.
- Legal Counsel Lester P. Dodd presented an opinion re validity of a clause in a component society's bylaws making it mandatory that any member missing more than one-third of its meetings without a legitimate excuse be dropped from membership; an opinion on a matter of ethics; a memorandum on advantages and disadvantages of incorporation of county medical societies; an opinion on potential liability of physicians serving on medical advisory boards for the medical re-evaluation of unfit automobile drivers. Legal Counsel has been studying the possibilities of organization of Kintner-type associations in Michigan through legislation or otherwise; he presented an opinion with respect to free choice of physician under Michigan's Compensation Act.
- Public Relations Counsel's report included information on state and federal legislation; the MSU Career Carnival of October 9-10 in East Lansing in which MSMS participation was approved by The Council; and information re the Constitutional Convention.
- Matters of mutual interest were discussed with State Health Commissioner A. E. Heustis, M.D., including (a) out-patient services in Howell; (b) financing of state tuberculosis hospitals; (c) deletion of Michigan Department of Health services; and (d) Council of Health members.

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mutually potentiating nonsteroid antirheumatics

"superior to aspirin"[2] and with a "higher 'therapeutic index'"[1]

In each yellow enteric-coated PABALATE *tablet:*

Sodium salicylate (5 gr.) 0.3 Gm.
Sodium para-aminobenzoate (5 gr.) 0.3 Gm.
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When sodium should be avoided—

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In each pink enteric-coated PABALATE-SODIUM FREE *tablet:*

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In each light blue enteric-coated PABALATE-HC *tablet:*

Same formula as PABALATE-SODIUM FREE, plus hydrocortisone (alcohol) . . . 2.5 mg.

1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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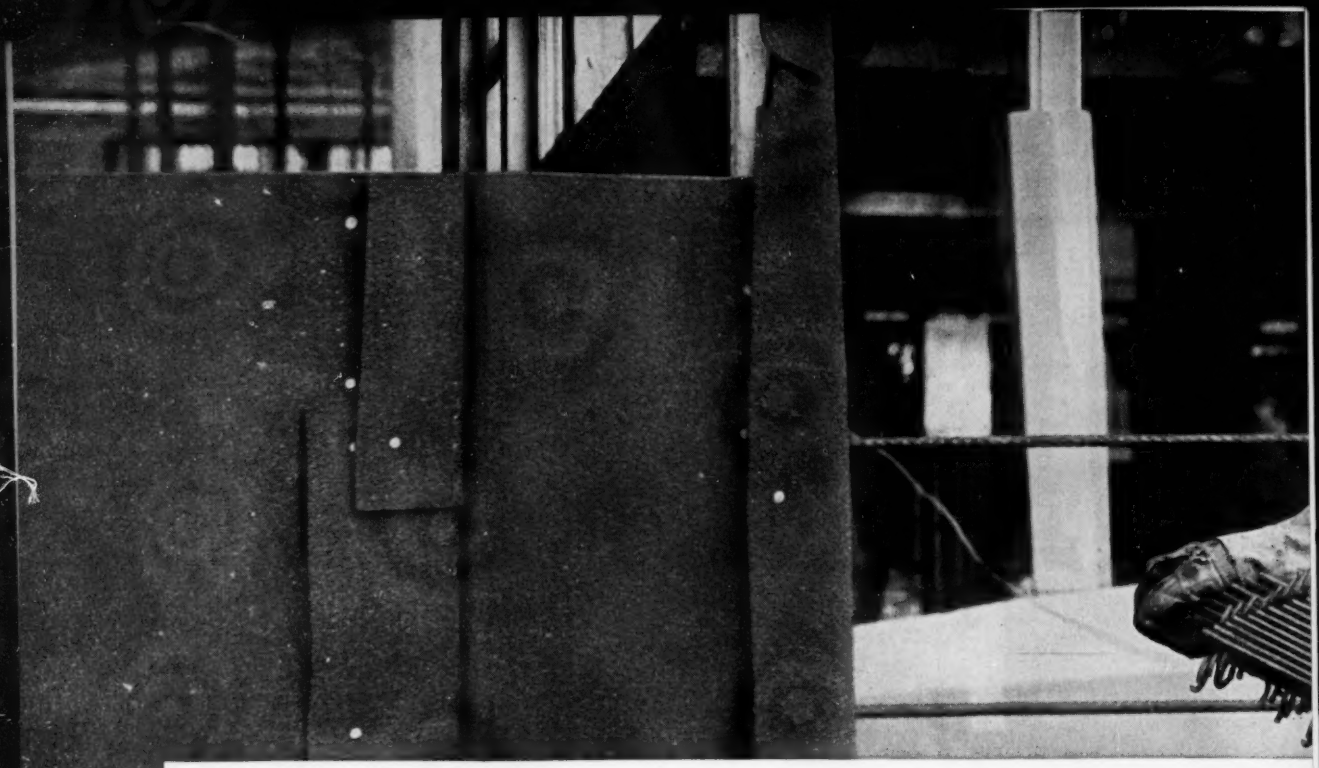
Making today's medicines with integrity . . . seeking tomorrow's with persistence.



Put your low-back patient back on the payroll

Soma's prompt relief of pain and stiffness can get your low-back patients back to work in days instead of weeks

Soma is unique because it combines the properties of an effective muscle relaxant and an independent analgesic in *a single drug.* Unlike most other muscle relaxants, which can only relax muscle tension, Soma attacks both phases of the pain-spasm cycle at the same time.

Thus with Soma, you can break up both pain and spasm fast, effectively . . . help give your patient the two things he wants most: relief from pain and rapid return to full activity.

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only with higher dosages. Soma is available in 350 mg. tablets. Usual dosage is 1 tablet q.i.d.

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

How you can help save your patients a month's pay

Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

Communications Potentialities Of the Printed Word

By Jean Worth, *Escanaba Daily Press*

(Second of several installments of a paper presented before the 1961 MSMS County Secretaries-Public Relations Seminar. The first part of the paper appeared in the June issue)

The nearly 3 billion people on the globe speak about 1,500 different languages, but fortunately our immediate problem isn't so large. Here in America English will do for internal purposes and this cozy fact tends to oversimplify our need, so that it is believed that if a problem and solution are presented nationally in saturation manner in the newspapers and magazines and on radio and TV, it will be solved. The Republicans know that this is not necessarily so.

What is the hope of the American Medical Association in public exchange with our free spending Congressmen on the inclusion of medical care of the aged under Social Security? Public opinion will decide this issue.

In a book on this subject and with this very name, "Public Opinion," Walter Lippman suggests that the angels are going to be on the side of the Congressmen in this one. He says "The practice of appealing to the public on all sorts of matters means always a desire to escape criticism from those who know, by enlisting a large majority which had had no chance to know.

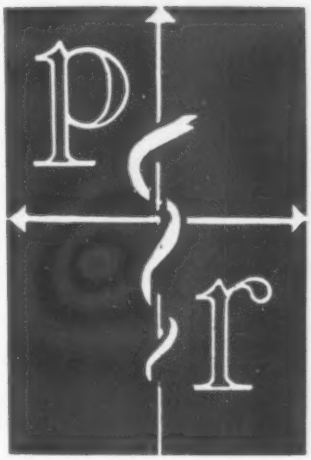
"News and truth," suggests Lippman, "are not the same thing. The function of news is to signalize an event and the function of truth is to bring to light the hidden facts and set them in relation with each other and make a picture of reality on which men can act. Only in a small part of the field of human interest do news and truth coincide.

"When we expect the press to supply the truth spontaneously we misunderstand the limited nature of news and the complexity of society; we over-estimate our own endurance and the public spirit and all-around competence. We suppose an appetite for uninteresting truths which is not discovered by any honest analysis of our own tastes.

"If newspapers are to be charged with the duty of translating the whole public life of mankind, so that every adult can arrive at an opinion on every moot topic, they fail; they are bound to fail; in any future one can conceive they will continue to fail. It is impossible to assume that a world carried on by division of labor and distribution of authority can be governed by universal actions in the whole population.

"The troubles of the press, like the troubles of representative government and like the troubles of industry, go back to a common source, to the failure of a self-governing people to transcend their casual experience and their prejudices by inventing, creating and organizing a machinery of knowledge.

"It is because they are compelled to act without a reliable picture of the world that governments, schools, newspapers and churches make such small headway against the more obvious failings of democracy, against violent prejudice, apathy, preference for the



curious trivial as against the dull important. This is a primary defect of popular government, a defect inherent in traditions, and all its other defects can, I believe, be traced to this one."

* * *

Lippman believes that only if problems are processed can the modern citizen cope with them intelligently. He says that on many subjects of great public importance the threads of memory and emotion are in a snarl and that "the same word will connote any number of different ideas."

* * *

More than 600,000 English words have been put together, each a symbol for a fact of meaning and—unfortunately—often for two or ten. We're told by the semanticists that modern man can convey small differences of meaning never possible to early man. This is an exactitude, however, which has brought with it tremendous problems of muddy symbolism that strongly affect modern communications.

In the use of words in communication we should be concerned with reaction to the word. People do not react to the dictionary explanation of the meaning of a word by means of other words, but to what the word symbolizes for them individually.

All of us tend to think that we use words the right way and that people who use the same words in other ways are dumb or crooked. Semanticist Samuel Hayakawa illustrates this point by citing that when the Russians use the word "democracy" for their own purposes in a way that outrages our definition of it we accuse them of propaganda, while they say our use is hypocrisy.

Alfred Korzybski, the founder of general semantics, says that persons who fuse off mentally in contact with such loaded words as "socialized medicine," "creeping socialism," "tax the rich," "Republican," "Democrat," "Catholic," "Jewish," "Roosevelt," "Kennedy," "Negro," etc., have short circuits. He calls them "identification reactions."

He uses "identification" in a special way to mean that such persons give such a fixed identity to such words that they give identical response to all occurrences of the word under all circumstances, no matter how differing. This is the situation when Democrats or Republicans react to the entire political campaign in terms of party labels only.

Korzybski believed that "identification reaction" described most cases of semantic malfunctioning. If we assume that everything has a "right name" and that the right name names the essence of what is named, we are apt to have reaction patterns that are subject to premature and often inappropriate responses. We're apt to react to names as though they give insight into persons or things.

To realize the difference between words and what they stand for helps us understand the differences and similarities in the world and is absolutely necessary for scientific thinking, as well as for sane thinking.

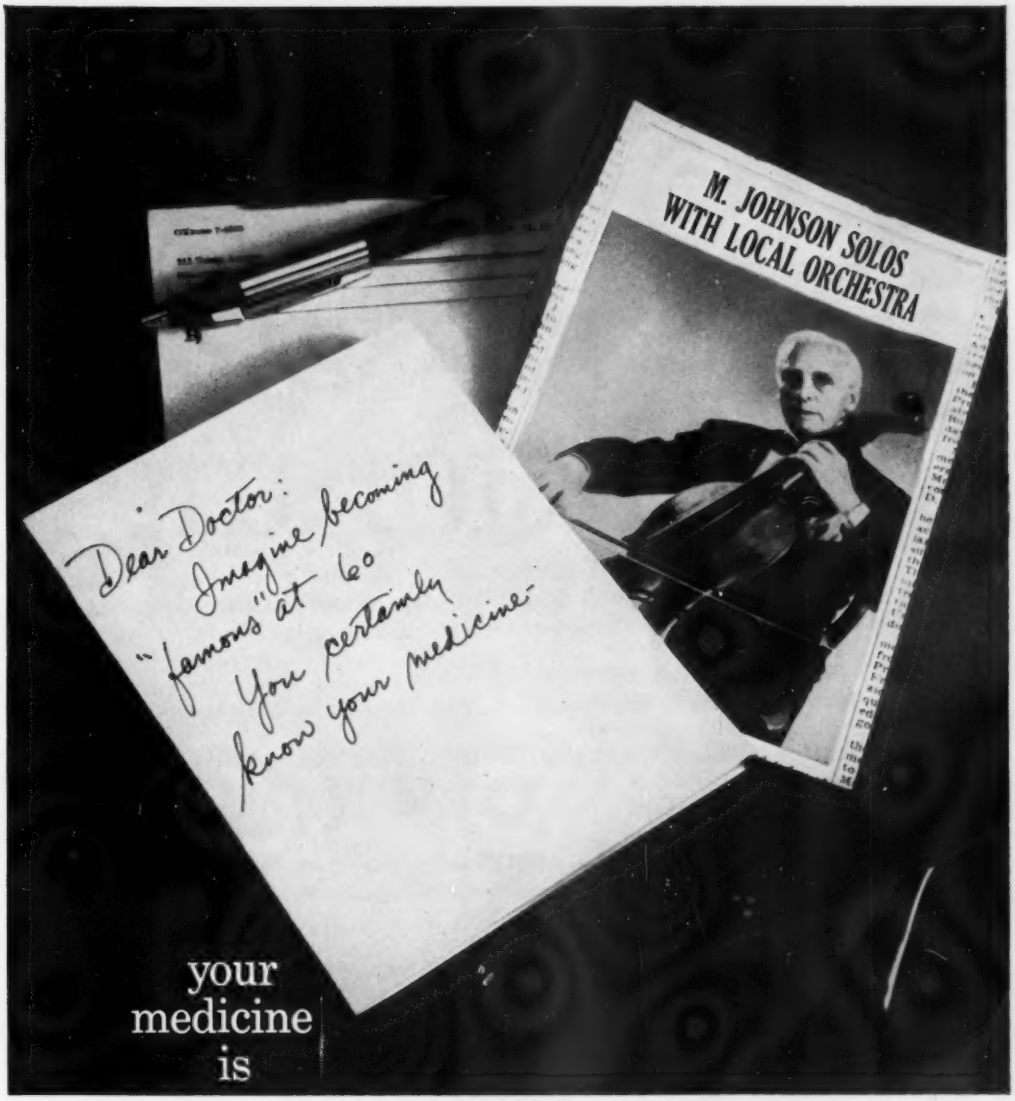
Berrien Society Explains Medical Career Opportunities

The Berrien County Medical Society recently sponsored a career program for high school youths from the area. August F. Bliesmer, M.D., St. Joseph, instigator, reports that they invited the juniors and seniors of our five area high schools, public and parochial, who were, or might be, interested in medicine as a career, to a meeting in the library of the St. Joseph High School, with 50 in attendance.

Six local doctors served on a panel. The film "I Am a Doctor" was shown, and material prepared by the AMA was distributed. The evening concluded with cokes, coffee, and sweet rolls. The book, "Admission Requirements of American Medical Colleges," was helpful in answering questions pertaining to admissions and costs.

* * *

U. S. Census Bureau reports size of average American family increased between 1950 and 1959 from 3.54 persons to 3.66 Southern families, with 3.81 persons, were larger than those in any other region.



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Geriatric Vitamins—Minerals—Hormones—d-Amphetamine Lederle

one capsule every morning supplements the diet to help achieve proper balance: ✣ nutritionally ✣ metabolically ✣ mentally

Each dry-filled capsule contains: Ethinyl Estradiol, 0.01 mg. • Methyl Testosterone, 2.5 mg. • d-Amphetamine Sulfate, 2.5 mg. • Vitamin A (Acetate), 5,000 U.S.P. Units • Vitamin D, 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate, 1/15 N.F. Oral Unit • Thiamine Mononitrate (B_1), 5 mg. • Riboflavin (B_2), 5 mg. • Niacinamide, 15 mg. • Pyridoxine HCl (B_6), 0.5 mg. • Calcium Pantothenate, 5 mg. • Choline Bitartrate, 25 mg. • Inositol, 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate, 50 mg. • l-Lysine Monohydrochloride, 25 mg. • Vitamin E (Tocopheryl Acid Succinate), 10 Int. Units • Rutin, 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.), 30.4 mg. • Iodine (as KI), 0.1 mg. • Calcium (as $CaHPO_4$), 35 mg. • Phosphorus (as $CaHPO_4$), 27 mg. • Fluorine (as CaF_2), 0.1 mg. • Copper (as CuO), 1 mg. • Potassium (as K_2SO_4), 5 mg. • Manganese (as MnO_2), 1 mg. • Zinc (as ZnO), 0.5 mg. • Magnesium (MgO), 1 mg. *Supply:* Bottles of 100 and 1,000.

REQUEST COMPLETE INFORMATION ON INDICATIONS, DOSAGE, PRECAUTIONS AND CONTRAINDICATIONS FROM YOUR LEDERLE REPRESENTATIVE OR WRITE TO MEDICAL ADVISORY DEPARTMENT.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

After 10 weeks of therapy– a clear skin, a new personality, a new world of fun and laughter

pHisoHex, used as a daily, exclusive wash, enhances any treatment for acne. Because it contains 3 per cent hexachlorophene, it supplies *continuous* antibacterial action to help combat the infection factor. pHisoHex cleanses better than soap because it is 40 per cent more surface-active.

Used together, pHisoHex and new keratolytic pHisoAc Cream provide basic complementary topical therapy for patients with acne—to unplug follicles and to help prevent comedones, pustules and scarring.

New pHisoAc Cream dries, peels and helps degerm the skin; flesh-toned, it tends to hide acne lesions as they heal.

pHisoHex, in unbreakable squeeze bottles of 5 oz. and NEW plastic bottles of 1 pint; pHisoAc in 1½ oz. tubes.

pHisoHex and pHisoAc, trademarks reg. U. S. Pat. Off.

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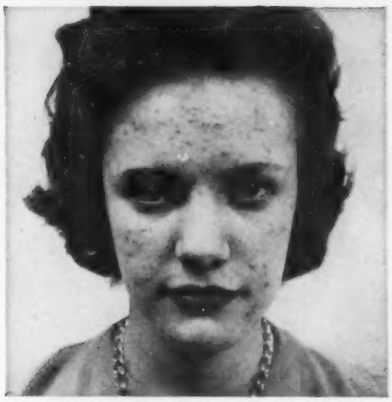


Acne vulgaris before treatment

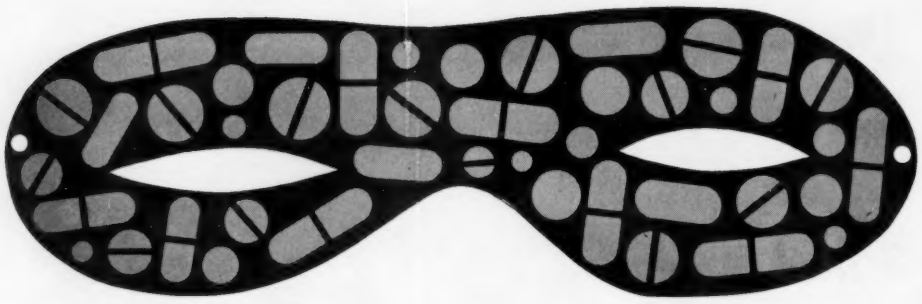
For treatment at home, this patient washed her face daily with pHisoHex and kept pHisoAc on her face twenty-four hours a day.

Nine office treatments consisted of mechanical removal of blackheads and applications of carbon dioxide slush. No other medication was given.

After 10 weeks of therapy

For Acne–pHisoHex® and
antibacterial, nonalkaline, nonirritating, hypoallergenic detergent

pHisoAc® Cream
keratolytic



drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia

SK&F

in bacterial tracheobronchitis

Panalba* promptly

to gain precious therapeutic hours

Panalba your broad-spectrum antibiotic of first resort

In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical in terms of the time and facilities available.

A rational clinical alternative is to launch therapy at once with Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
Usual Adult Dosage: 1 or 2 capsules 3 or 4 times a day.
Side Effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, a few cases of leukopenia and agranulocytosis have been reported in patients treated with Albamycin. Most of these side effects usually disappear upon discontinuance of the drug.
Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.
Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

*Trademark, Reg. U.S. Pat. Off.
The Upjohn Company
Kalamazoo, Michigan

Upjohn
75th year

Available only to physicians for their distribution—

Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

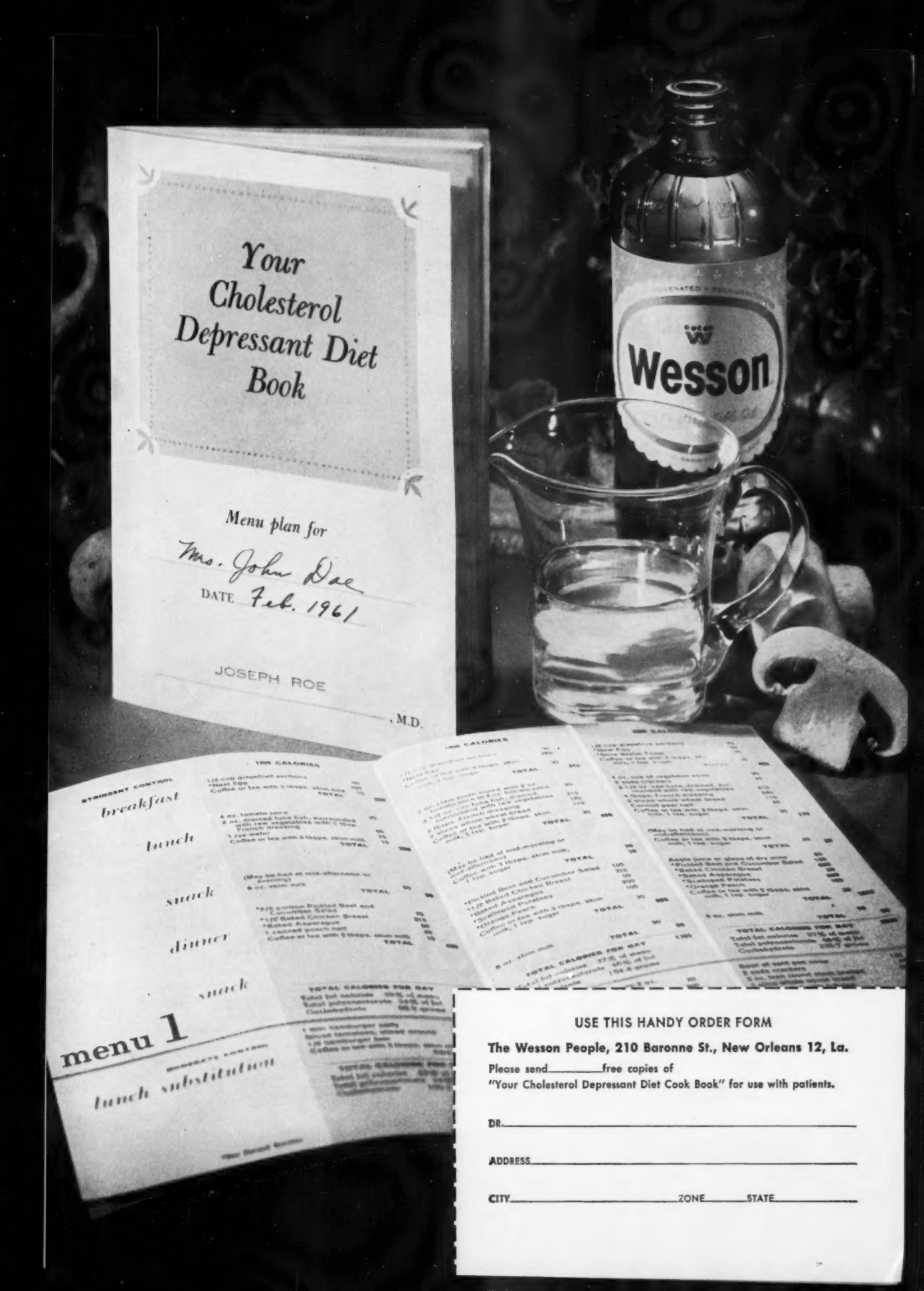
WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil—winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



USE THIS HANDY ORDER FORM

The Wesson People, 210 Baronne St., New Orleans 12, La.

Please send_____free copies of
"Your Cholesterol Depressant Diet Cook Book" for use with patients.

DR._____

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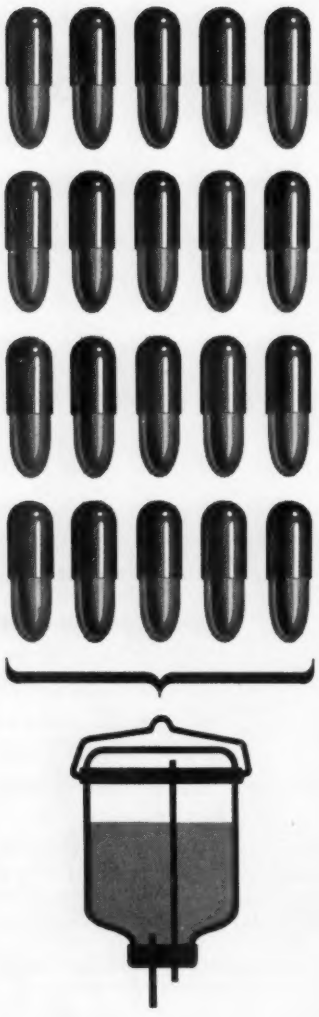


■ See
both blood picture
and patient respond to

TRINSICON®

(hematinic concentrate with intrinsic factor, Lilly)

For a rapid hematological response
. . . striking clinical improvement

Two Pulvules® Trinsicon daily are capable of producing in ten days an Hb and RBC response comparable to that obtained after a transfusion of one pint of whole blood. For potent, complete anemia therapy, prescribe Trinsicon . . . *just 2 a day for all treatable anemias.*

Two Pulvules Trinsicon (daily dose) provide:

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor) . . . . 300 mg.

Vitamin B_{12} with Intrinsic Factor Concentrate, N.F. . . . . 1 N.F. unit (oral)

Cobalamin Concentrate, N.F., equivalent to Cobalamin . . . . . 15 mcg.
(The above three ingredients are clinically equivalent to 1½ N.F. units of APA potency.)

Ferrous Sulfate, Anhydrous . . . . . 600 mg.
(Equal to over 1 Gm. Ferrous Sulfate, U.S.P.)

Ascorbic Acid (Vitamin C) . . . . . 150 mg.

Folic Acid . . . . . 2 mg.

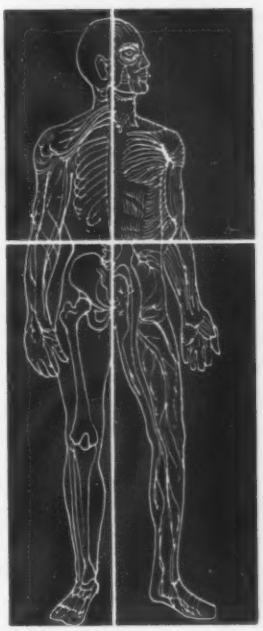
119008

An Evaluation of the Etiologic Survey In Chorioretinitis

Conrad L. Giles M.D.
Alan Lewis, M.D.

Ann Arbor, Michigan

CLINICAL 1001



ALTHOUGH chorioretinitis is primarily diagnosed and treated by the ophthalmologist, there is virtually no segment of the medical community which at some time is not called upon to evaluate patients exhibiting the disease.

As the term implies, chorioretinitis, or posterior uveitis, is an inflammation of the choroid and retina. The diagnosis is made on the basis of an ophthalmoscopic examination and presents little difficulty.

The ophthalmoscopic picture of chorioretinitis is variable. The inflammatory process can result in great exudation with clouding of the vitreous cavity and obscuration of retinal detail. Often, however, the exudation is mild and detailed areas of exudate, which appear as white cloudy patches with irregular borders about the size of the optic disc, can be seen surrounded by the normal retina (Fig. 1). Less frequently, the lesion may be cystic with a surrounding collarette of hemorrhage in or near the macula or periphery, and they may be multiple or single (Fig. 2). Those lesions occurring centrally are associated with a loss of central visual acuity, often acute in onset whereas when the process is more peripherally located, mild blurring is the patient's primary complaint.

Because scarring of the involved area is a frequent end result of chorioretinitis, centrally located lesions pose a definite threat to the preservation of useful vision (Figs. 3 and 4). It is for this reason that the institution of specific therapeutic measures is so important.

The etiology, however, is usually obscure, and therapy is most often based on indirect clinical and laboratory evidence of causative agents. This is necessary because culture and biopsy, the usual methods of isolation of organisms, are not available to the clinician treating conditions affecting the posterior segment of the eye.

As a result of this necessarily indirect aprpoach to diagnosis, the list of possible etiologic factors is long (Table I), the evidence on which each is based often tenuous, and the therapeutic regimens employed are legion.[1]

From the University of Michigan Medical Center, Ann Arbor, Michigan.

Since 15 per cent of all known blindness in this country is a result of inflammatory conditions of the eye, it behooves the ophthalmologist to periodically evaluate the etiologic survey methods he employs in an attempt to learn which portion of his work-up is valuable and which portion is not.

This report deals with the etiological survey in 100 consecutive cases of chorioretinitis seen in the University of Michigan Medical Center between February, 1959, and July, 1960.

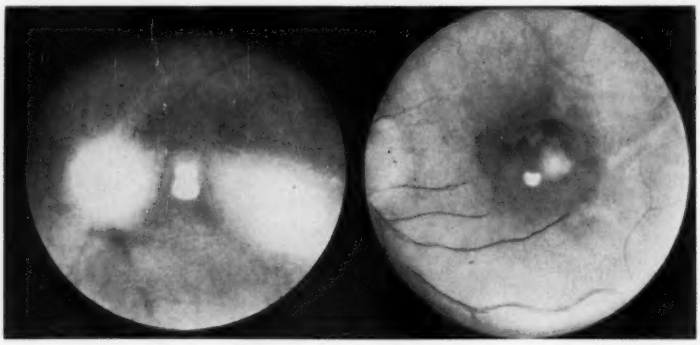


Fig. 1. Acute chorioretinitis with exudative lesion present temporal to the optic nerve and located in the macula. The overlying vitreous is hazy as a result of inflammatory products.

Fig. 2. This is a fundus photograph of an acute chorioretinitis characterized by a cystic elevated area of retina in the macula surrounded by a collarette of hemorrhages.

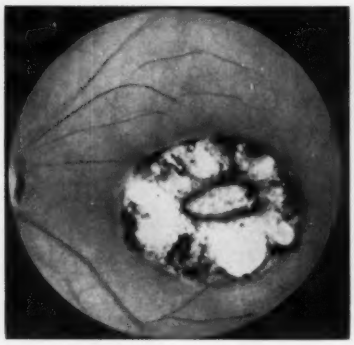


Fig. 3. A fundus photograph of healed, inactive macular chorioretinitis. This patient was legally blind in this eye and was only able to count fingers at a distance of 2 feet.

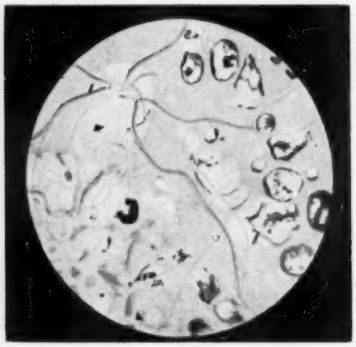


Fig. 4. This is a drawing of healed, inactive, central and peripheral chorioretinitis with an unusually large amount of retinal destruction.

Review of Literature

Since 1850 when major interest was first focused on chorioretinitis many etiologies have passed in and out of fashion.

In the middle 1800's syphilis, tuberculosis and "rheumatism" were most often implicated as causes of uveitis. These entities remained as prime considerations until 1900 when the concept of focus of infection supplanted these entities as the most favored etiologic diagnosis. For the first quarter of this century focus of infection and syphilis equally shared the etiologic limelight, but with the increased utilization of serologic technique, it slowly became apparent that leutic infection was only infrequently associated with uveitis.

The use of the tuberculin skin test increased the emphasis of clinicians on tuberculosis as a major cause of chorioretinitis after 1925. The most important recent contribution to the search for etiologies in chorioretinitis was made by Wilder in 1952 when she discovered *Toxoplasma gondii* in the necrotic chorio-

retinal lesions in adult eyes which had previously been diagnosed as typical tuberculosis but in which tubercle bacilli could not be found. It is now generally recognized that not only is toxoplasmosis a proven cause of uveitis, but that it is one of the most important causes.[2]

In 1941 the first in a series of reports on etiologic surveys from the Wilmer Institute was published. Tables II, III and IV contain the data from the Wilmer studies[2-4] and are included for interest and comparison with this report.

TABLE I. ETIOLOGIC FACTORS

Chorioretinitis
- Protozoal
  - Toxoplasmosis
- Bacterial
  - Tuberculosis
  - Syphilis
  - Brucellosis
- Fungal
  - Histoplasmosis
- Parasitic
  - Cysticercus
  - Toxocara
  - Filaria

Generalized Uveitis
- Tuberculosis
- Sympathetic Ophthalmia
- Vogt—Koyanagi—Harada
- Behcet's
- Pyogenic Endophthalmitis
- Sarcoidosis

A series very similar to this report was published by Schlaegal[5] in 1958 (Table V). This author concludes that "the diagnosis made will depend on the diagnostic acumen, battery of tests employed, the individual worker's opinion as to the relative importance of various etiologic agents, and rigidity of criteria for making of a diagnosis."

TABLE II. WILMER INSTITUTE ETIOLOGIC SURVEY (GUTON, WOODS)
(1925-1939)
562 Cases

Etiology	Per Cent With Definite Diagnosis	Per Cent With Presumptive Diagnosis	Total
Tuberculosis	23.5	26.1	49.7
Lues	8.0	2.5	10.5
Sarcoid	0.5	0.0	6.5
Brucella	0.2	0.2	0.4
Foci of infection	5.5	20.6	26.1
Gonorrhea	1.8	2.8	4.6
Nongranulomatous systemic disease	2.5	3.4	5.9
Metabolic disease	0.0	0.5	0.5
Miscellaneous	1.4	0.4	1.8

In another recent report, Perkins[6] presents a series of 653 cases of uveitis where a 4.4 per cent incidence of association with ankylosing spondylitis and a 2.1 per cent incidence with sarcoidosis was found. In this same series, 50 per cent of 106 cases with chorioretinitis showed a positive Dye test for toxoplasmosis.

The English workers in this field are now emphasising the importance of the association of prostatitis with chorioretinitis. This work has excited little interest in the United States, but may be of greater importance than is now realized.

TABLE III. WILMER INSTITUTE ETIOLOGIC SURVEY (WOODS)
157 Cases

Etiology	Per Cent
Tuberculosis	52
Lues	17
Sarcoid	10
Brucella	10
Toxoplasmosis	0
Histoplasmosis	0
Miscellaneous	5
Undetermined	6

Thus it would appear that a full cycle has been reached and the influence of foci of infection on chorioretinitis may again be coming into the etiologic limelight.

TABLE IV. WILMER INSTITUTE ETIOLOGIC SURVEY (WOODS)
(1950-1960)
432 Cases

Etiology	Per Cent
Acquired toxoplasmosis	30.9
Tuberculosis	27.0
Toxoplasmosis or tuberculosis	6.7
Lues	4.6
Sarcoid	4.4
Brucellosis	4.9
Histoplasmosis	3.9
Miscellaneous	1.4
Undetermined	15.5

Method of Study

The case records of 100 consecutive posterior uveitis patients investigated at the University of Michigan Medical Center between February, 1959, and July, 1960, were examined.

All of these patients, in addition to a detailed ophthalmologic examination, received a diagnostic survey which routinely included the following tests: (1) Chest microfilm, (2) Serological test for syphilis (Kahn test), (3) Urine sugar and albumin, (4) Tuberculin (OT 1:4000) skin test, (5) Histoplasmosis skin test, (6) Coccidiodomycosis skin test, (7) Blastomycosis skin test, (8) Toxoplasmosis skin test and control, (9) Frei skin test and control, (10) Complement fixation studies to histoplasmosis, coccidiodomycosis and blastomycosis.

In addition, the majority of patients received Brucella agglutination determinations. The Sabin-Feldman titer (toxoplasmosis) was drawn at the discretion of the examining physician.

TABLE V. ETIOLOGIC SURVEY (SCHLAEGAL) 100 Cases

Test Performed	Per Cent Positive Results
Positive OT skin tests	67
Positive histo skin tests	38
Positive toxo skin tests	58
Positive serology for lues	3
Brucella agglutinins	7
Urinalysis	Negative
Sabin-Feldman dye test 1:4 or greater	68
Chest x-ray	40
Consultations—not done	
Probable diagnosis	17

Consultation with the Departments of Urology, Internal Medicine, Oral Surgery, Otology and Gynecology were obtained in a large segment of this group of patients.

Result of Survey

Sex Incidence.—There were 58 males and 42 females in this series.

Age Incidence.—The youngest patient in the series was seven years of age; the oldest 69. The average age of onset of the disease was 35, in both the male and female groups.

Chest Microfilm.—The chest microfilm was negative in 76 cases and revealed some abnormality in 24 patients. An active disease process was not found in any of this latter group of patients.

Serologic Test for Syphilis, Urine Sugar and Albumin.—A positive Kahn test was not obtained in any patient and no patient exhibited either albuminuria or glycosuria in this series.

Skin Tests.—The results of skin testing are listed in Table VI. A scant majority of the patients exhibited a positive toxoplasmin skin test (54 per cent). No case demonstrated a positive skin test control and positive active antigen simultaneously in the toxoplasmin sensitive group. Thirty-two per cent of the patients exhibited a positive histoplasmin skin test, while only 25 per cent showed tuberculin hypersensitivity. Three per cent of the group were positive to coccidiodin antigen and one patient questionably demonstrated Frei test sensitivity.

Of particular significance is the fact that 32 patients had at least two positive skin tests.

Complement Fixation Studies.—The studies for histoplasmosis, coccidiodomycosis and blastomycosis complement fixation were entirely negative in 77 patients. Thirteen patients showed significant histoplasmosis titers. In four of this group concomitant titers were present to coccidiodomycosis and/or blastomycosis.

The serum in the remaining ten cases was anticomplementary.

All studies were obtained from the Public Health Service Laboratories in Chamblee, Georgia.

Brucella Agglutination.—Brucella agglutination levels were obtained in 83 cases. Three cases were positive. In repeat determinations, however, no patient exhibited a rising titer of Brucella agglutination.

TABLE VI. POSITIVE SKIN TESTS

Antigen	Number
Histoplasmin	32
Tuberculin	25
Coccidioidin	3
Blastomycin	0
Frei	71
Toxoplasmin	54

Sabin-Feldman Dye Titers.—Sabin-Feldman Dye determinations were made in 43 of the 54 patients exhibiting positive skin tests with toxoplasmin antigen and in 20 of the 46 patients in whom negative toxoplasmin skin tests were obtained. Thus, 63 Sabin-Feldman Dye studies were reported. The positive skin test group demonstrated positive titers in 37 out of the 43 patients tested, while those cases with negative skin tests showed positive Sabin-Feldman Dye titers in 6 out of 20 patients (see Table VII).

Foci of Infection.—When focus of infection studies were initiated, consultation was routinely obtained with the Departments of Otology, Urology and Oral Surgery. In selected cases, Internal Medicine and Gynecology consultation was also obtained.

The only significant positive findings in the 29 patients who were so referred were reported by the Department of Oral Surgery. In four cases they felt that abscessed or carious teeth might account for a possible source of focus of infection.

Discussion

No attempt will be made to correlate final visual acuity with the various therapeutic regimens employed because of insufficient follow-up, but rather the discussion will center on the influence of the diagnostic evaluation on the selection of therapy.

Since none of the eyes in this series were available for tissue diagnosis or culture, all diagnoses must be considered presumptive rather than definitive. A presumptive diagnosis was arrived at in only 52 out of the 100 cases analyzed. These are listed in Table VIII. The three etiologies implicated in this group included toxoplasmosis, histoplasmosis and sarcoidosis.

The diagnosis of toxoplasmosis was made on the basis of a positive Sabin-Feldman titer of 1:16 or greater with a compatible fundus picture, usually consisting of an exudative choroiditis, most often seen in younger individuals and commonly associated with multiple areas of healed chorioretinitic leisons.

Histoplasmosis was considered the presumptive diagnosis in 13 patients where the following criteria were present[7]: (1) Positive histoplasmin skin test; (2) complement fixation titers of 1:8, or greater;

TABLE VII. SABIN-FELDMAN DYE TITERS

	Positive Toxoplasmin Skin Tests	Negative Toxoplasmin Skin Tests
1:16	3	1
1:32	3	2
1:64	5	0
1:128	7	0
1:256	5	1
1:512	5	1
1:1014	2	0
1:2048	8	1
1:4096	3	0
1:8192	2	0
Total	43	6

(3) "typical" ophthalmoscopic picture of chorioretinal macular disease. There were several cases in the histoplasmosis group that, in addition to the above criteria, demonstrated elevated Sabin-Feldman Dye titers. These cases were considered to be presumptively due to histoplasmosis since the clinical picture closely followed that described for histoplasmosis. The single diagnosis of sarcoidosis was made in a patient who exhibited nothing in addition to pulmonary lesions compatible with the previously substantiated tissue diagnosis of systemic sarcoidosis.

Conspicuous by its absence as an etiologic agent in this list is tuberculosis. Although 25 per cent of the patients exhibited tuberculin hypersensitivity, it was felt that the presence of a positive skin test alone or in combination with pulmonary calcification was insufficient evidence upon which to base a presumptive diagnosis. Its importance lies in the election of a therapeutic program.

There are four treatment programs employed at the University of Michigan Medical Center. These include the use of intravenous Amphotericin B (Fungizone, Squibb) with sulfadiazine in presumptive histoplasmosis, and the ultilization of Daraprim and sulfadiazine in cases of presumptive toxoplasmosis chorioretinitis.

In the remaining cases in which no presumptive diagnosis was arrived at (and in the single case of sarcoidosis), treatment with systemic steroids was instituted. In this group, treatment with isonicontinic hydrazide (INAH) and paraamino-salicylic acid (PAS) was added to the regimen if tuberculin hypersensitivity was present. This was done for two

TABLE VIII. PRESUMPTIVE ETIOLOGIC DIAGNOSIS
100 Cases

Etiologic Disease	Per Cent
Toxoplasmosis	38
Histoplasmosis	13
Sarcoidosis	1
Unknown	48

reasons. The first and most important reason was to "cover" the patient with antituberculous drugs in order to prevent a flare of an old tuberculous process. Second, this also treated the remote possibility that tuberculosis was the etiologic agent involved in the chorioretinitis.

Although a possible focus of infection was thought to be present in four cases, the presumptive diagnosis of chorioretinitis secondary to this focus was not seriously considered. It is generally felt by the Department of Ophthalmology at the University of Michigan Medical Center that in the light of our present knowledge the concept of a focus of infection causing chorioretinitis must be considered unlikely and that consultation with allied services should be reserved for selected difficult cases.

It is obvious that in spite of an extensive etiologic survey, with many laboratory tools, just as often as not the ophthalmologist is left in the undesirable position of having to treat a devastating disease with non-specific therapy. In this series only 3 tests measurably contributed to the institution of specific therapy. These included the skin tests and complement fixation studies to the chronic granulomatous diseases and the Sabin-Feldman Dye titer.

The employment of both the toxoplasmin skin test and Sabin-Feldman Dye study in the diagnostic survey deserves further mention. Although the toxoplasmin skin test is a good indicator of possible toxoplasmic chorioretinitis, it is far from infallible and it is not recommended that the skin antigen be used to the exclusion of the Dye study. As noted earlier in this report, negative Dye studies were obtained in the presence of positive skin tests (6 of 43) and postive Dye titers were found where negative skin hypersensitivity to the toxoplasmin antigen was absent (6 of 23 cases). It is therefore advisable that

both tests be routinely used in the chorioretinitis etiologic survey.

The value of the skin test lies in the availability of the report after forty-eight hours, whereas the Sabin-Feldman Dye titer report is usually delayed at least two to three weeks.

The focus of infection survey, chest film, serological test for syphilis, urine sugar and albumin, and brucella agglutination did *not* significantly contribute to the therapy in a single patient so studied.

This is of practical value to the ophthalmologist treating chorioretinitis in private practice. At the University of Michigan Medical Center the chest film, urinary studies and serological test for syphilis are routine and there is no charge beyond the usual registration fee for these procedures. Referring patients to the various clinical services carries with it a nominal charge. This is not the case in the private practice of ophthalmology where the laboratory and consultation fees would be proportionately larger.

Because of the often devastating nature of the disease, it would still be ideal if all patients with chorioretinitis were exhaustively studied in an attempt to implicate even the most remote etiologic possibility. Unfortunately, this is not possible and not infrequently a practical compromise must be sought.

When economic and social considerations dictate a shortened uveitis etiologic evaluation, it is therefore recommended that the following survey be employed:

1. Skin tests to toxoplasmosis (and control), histoplasmosis and tuberculosis.
2. Complement fixation studies to histoplasmosis, coccidiodomycosis and blastomycosis.
3. Sabin-Feldman Dye titer.

The charges for these procedures are quite reasonable. The skin testing material to histoplasmosis and tuberculosis is supplied free of charge by the State Laboratories in Lansing, Michigan. Toxoplasmin skin-testing material can be obtained from the El Liilly Company.

The complement fixation studies can be obtained by sending 10 cc. of clotted blood to the State Laboratories from where it is then transported to the United States Public Health faculty in Chamblee, Georgia. This is done at no charge to the patient.

We have been sending blood samples for the Sabin-Feldman Dye titer (toxoplasmosis) to the South Bend Medical Foundation in South Bend, Indiana. The fee for this test is $15.

Thus, with this abbreviated workup it is possible to perform the most important facets of an extensive outpatient evaluation at a cost of less than $30. This is an important consideration in most economic situations.

Summary

1. The results of the etiologic survey utilized in the evaluation of patients with chorioretinitis at the University of Michigan Medical Center between February, 1959, and July, 1960, are analyzed.

2. A presumptive etiologic diagnosis was made in slightly over one-half of the cases.

3. Cases diagnosed as toxoplasmosis chorioretinitis received Daraprim and sulfadiazine therapy often combined with systemic steroids. Those patients with a presumptive diagnosis of histoplasmosis had Amphotericin B administered intravenously and received sulfadiazine orally. In those patients where no etiologic agent was uncovered in the survey, systemic steroid therapy was used.

4. An abbreviated etiologic evaluation is outlined for those situations where social and economic conditions dictate the need for such a program.

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Ocular Photography

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THE PURPOSE of this paper is to illustrate how anyone can take excellent photographs of the eye utilizing moderate cost equipment available in almost every photographic supply store.

Equipment

Equipment requirements include: (1) Camera—Contaflex III; (2) Illumination—Heiland Strobonar, Model 64B and quick release brackets; (3) Lenses—Proxar 0.2 meters, 0.3 meters; (4) Special Supplementary Lens; and (5) Microscope Adapter Ring (Zeiss Co. for Contaflex)—all at total cost of about $200.00.

The Camera.—Any single reflex could be used, but we recommend the Contaflex III single lens reflex, 35-mm. camera because of its versatility, compactness, precision workmanship and excellent optical qualities. It is a single lens reflex type camera embodying a singlar lens system for viewing and taking the picture. This feature allows the photographer to view exactly what he is going to record without problem of parallax, which could be of great significance when one takes such extreme close-up pictures. A single lens reflex camera eliminates this completely.

The viewing system is especially bright, large, and being eyelevel is handy to use.

The shutter is a compur type having a variety of speeds, as well as being internally snychronized for all artificial illumination: that being "M" for flashbulbs, and "X" for strobe light.

The lens is an f2.8, 50 mm. Zeiss product with f-stops from 2.8 to 22.

The focusing ring is mounted anteriorly on the camera easily within finger reach.

The 1960 Contaflex models have made it possible to purchase the older Models I, II, and III at bargain prices—ranging from $65 to $110 for the I and III, respectively, and allowing substantial reduction in total equipment cost.

Illumination.—In color photography, one desires so-called "flat-lighting." This is to say, lighting without shadow. In black and white photography, degrees of shadow are desirable when utilized properly, but not with color photography. Therefore, it is best to position the strobe unit so it will be centered in front of the face; thereby equally lighting both sides (Fig. 2A). Not only that, but in this position it also illuminates the background on both sides of the head.

Fig. 1. Shown is the complete equipment necessary to take ocular photographs—camera, lenses, microscope adapter, and strobe light and brackets.

We use a Heiland Model 64B strobe light. Of particular importance is the fact that the strobe face is relatively small in size, producing only a small reflex on the cornea on extreme close-up photos. It should be noted here that when working close to the face it is not practical to use flash bulbs because of the danger of bulb explosion.

From the Detroit Receiving Hospital. Dr. Slack is a Resident in Ophthalmology, Kresge Eye Institute, Detroit, Michigan.

The strobe light does not have this dangerous feature and lends itself easily to this type work. It is a repetitive flash of about 1/2000 second duration, color balanced to daylight film, and with a maximum power output of 45 watt seconds. The strobe flash-tube will give about 10 to 15,000 successive flashes with an average time interval of 5 to 25 seconds between flashes for the recycling procedure. The Heiland Model 64B strobe light is activated from house current or from 3 D-size ordinary flashlight batteries. This gives a recycle time of 5 seconds on house current, and 25 seconds on batteries. Both recycling times are short and of little inconvenience. With recycling completed a "ready light" glows visibly indicating the unit is ready to flash again.

When being operated on batteries, the unit is completely contained in one piece with no cords dangling down to a separate power pack. This facilitates its portability, with one carrying it easily into the Emergency Room or Operating Room. The electrical unit is self-contained when in this portable form and so offers only little opportunity of external electrical discharge and subsequent anesthetic explosion in an operating room.

It is simple to pick up the camera unit, plug in the flash, expose and keep right on exposing just as easily. For a picture in the next room, simply flip the switch to the battery cycle, and it will be "ready" by the time you get there. It is easily carried from room to room, building to building, or city to city.

Fig. 2a. This is the basic method of holding the camera and light for all situations except the ultra-close pictures. Note how the left hand holds the back of the strobe light against the forehead and directed at the subject.

Fig. 2b. The camera body is held the same way with the right hand, but the strobe light is in a slightly changed position. It now is held to the left side and close to the left edge of the camera bracket, while being directed more inward toward the eye.

This particular strobe light does have some disadvantages, though. It is too heavy to carry about all day, weighing 2 pounds 15 ounces with batteries, but for our use it is perfectly satisfactory. Also, the unit's power is adequate for close pictures but not adequate for anything farther away than 10 feet when using Kodachrome film. It cannot be used continuously on batteries, either. It must be "recharged" occasionally with house current, but this feature is negated by using it in the office as suggested in this paper.

The strobe light manufacturers make a special bracket to attach the strobe light to the camera. It is designed to allow quick and easy release of the light from the camera. They call it appropriately a "quick release" clamp. Because the synchronization cord is coiled and extends to about 4 feet in length the light may be placed in multiple special positions while detached from its camera bracket.

Film.—Kodachrome Daylight type is used for almost all our work as it gives good, balanced colors

and with our strobe light is fast enough for our working conditions. At present we are experimenting with Ektachrome film with the slit lamp technique to achieve a higher f-stop and more depth of field.

In our transparency copying technique we use Kodachrome (Professional) Type A film.

Techniques

Holding the Camera.—The camera is light enough to be held comfortably with one hand—the right one. You grasp it in the right hand with the index finger poised to push down the shutter release on the top of the body at the right end of the camera (Fig. 3). The strobe light is manipulated with the left hand.

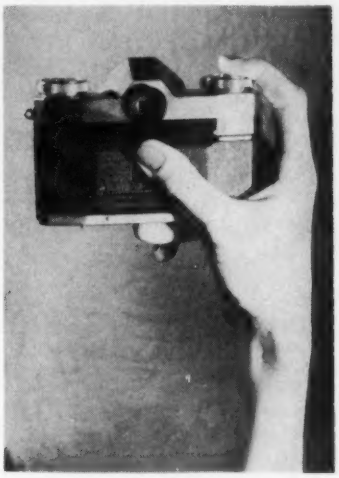

Fig. 3. The ease with which one can easily hold the camera is shown here. Note the right index finger poised to trip the shutter release located atop the right side of the camera within the knurled ring.

Following each exposure, merely slip the U-shaped end of the strobe light bracket into the curved index finger of the left hand. This fixates the camera, allowing release of the camera from the right hand. Then with the right hand you turn the knurled knob at the right end of the camera, simultaneously advancing the film, counting the frame, and cocking the shutter (Fig. 4). It is easy to again grasp the camera with the right hand, and continue on to take another picture. This procedure of advancing from one picture on to the next takes about 5 seconds.

Lenses Used.—We utilize the Contaflex standard close-up (Proxar) supplementary lens to focus from 2.5 feet to 6.25 inches. These are easily attached to the front of the camera with slip-on mounts. For bilateral ocular views to include the forehead, nose, lips, and ears, use the .3M (meter) lens. To concentrate detail on just both eyes, the .2M lens is used (Figs. 5-7).

Because the camera is so close to the face in taking the close-up pictures (about 4 inches to 6 inches), it is of great concern to have as streamlined a close-up lens as possible on the camera. This will give plenty of room to get the strobe lighting to the eye. To eliminate this problem we had a special lens ground for our ultra-close pictures, a lens which is as thin as possible yet powerful enough. One could add 2 or 3 .2M lens on top of each other and get the desired effect, but the combination of lenses is large and projects close to the face, blocking out some of the strobe illumination.

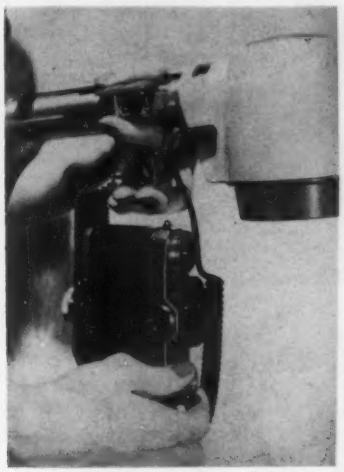

Fig. 4. The camera is shown supported in the curved fingers of the left hand while the right hand advances the film for the next picture.

A plus 21D lens will focus the camera so that the interpalpebral area of one eye fills almost the whole frame—a slightly greater than 1:1 ratio (Fig. 8). This lens was specially ground at a local optical company* and fit into a standard camera filter mount. The lens can be coated readily if you so desire to reduce reflections.

Recently Zeiss has offered a close-up lens element for the Contaflex III which gives a 1:1 ratio. The lens

*Bayne Optical Company

is actually three lens in a single unit which replaces the front lens elements of the 50 mm. regular Contaflex III lens. It is worthy to note that this new lens will *not* adapt to any Contaflex I or II, but only models III, IV and the newer models, all of which have interchangeable front lens elements.

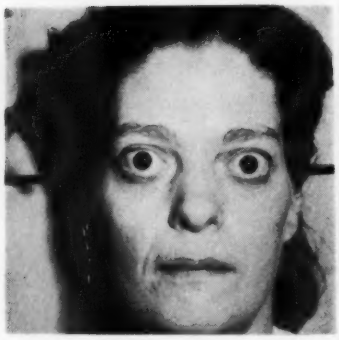

Fig. 5. This shows the field covered without any supplementary lens and with the camera focused at 2½′.

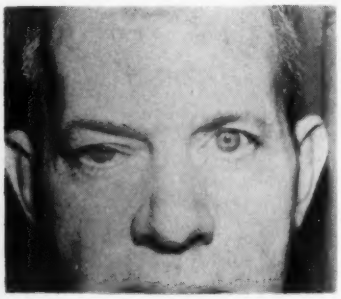

Fig. 6. Using the .3M lens the field photographed is roughly limited to the face alone.

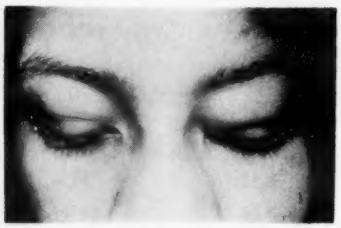

Fig. 7. Using the .2M lens only the area immediately about the two eyes is included. Note the small upper lid tumor located medially O.S.

Camera Settings (f-stops and time).—The flash duration for the strobe is 1/2000 second. With the shutter set for 1/250 or 1/500, there is little light except that of the strobe recorded on your film so the shutter speed is said to be "1/2000th second." This means that you "freeze" all action of the eye. It also allows you to slowly move backward and forward with ease while focusing and to trip the shutter while actually moving about. Because of this high shutter speed you do not get blurred pictures.

The f-stop designation is the size of the opening in the leafs of the shutter diaphram. The higher the stop, the smaller the opening, and also the greater the depth of focus achieved. When considering the proper f-stop, the degree of pigmentation and skin color in general is of importance. In the very young, elderly, and chronically ill the skin is very light, requiring a higher f-stop than in the normal, ruddy complexioned person.

With the camera utilized without extra lens and focused at 2.5 feet, one finds f5.6 is the correct f-stop for all but the very lightest complexioned subjects. (For the light complexioned person, we go to f8.). When utilizing any of the close-up lens, including the special lens, f11 is the setting to use with the normal person. If the patient is either very young or elderly, pale, and blue eyed, f16 should be used.

Summary

Without Supplementary Lenses—focus at 2.5 feet
f5.6—normally pigmented person
f8.0—light complexion person
With all Supplementary Lenses
f11—normally pigmented person
f16—light complexion person

In general, one can say f11 is utilized when photographing normal complexioned people using any of the supplementary lens. Experience will quickly tell you when to use a larger or smaller f-stop.

Focusing.—As previously stated, the Contaflex is a single lens reflex type camera, with the operator viewing and focusing through the one lens complex. A mirror is interposed between the lens and the film plane, reflecting the rays of incident light to the viewing system. An instant before exposure the mirror slips away allowing the light rays to go to the film plane and expose the film. This method of viewing and focusing allows the operator to see exactly what the camera will record at exposure.

When focusing through the Contaflex viewing system, one sees a central clear area on the ground glass having a "doughnut configuration." The outer ring of the "doughnut" is a fine ground-glass focusing area, while the central "doughnut hole" is a split image type rangefinder. To focus with the former you merely get the desired image sharp and clear on the ground

glass by moving the camera focusing ring back and forth until you reach the desired focus. The split-image rangefinder in the "doughnut hole" is slightly different. Here you select some vertical place to focus on. When the camera is out of focus the vertical lines are not in alignment and appear separated a few millimeters on the 180 degrees Meridian. When the camera is in focus the two vertical lines will be in vertical apposition forming a straight line in the 90 degree Meridian. The focusing is fully discussed and well illustrated in the camera manual.

A very great advantage of this technique and equipment is that we are able to place the focus of the camera on the pathology instead of utilizing the more common but less efficient method of prefocused lens coupled with frames. Frequently the patient's facial and ocular configuration will not allow the frame to get the area you desire into crisp focus, and a blurry picture results. This method allows you to focus exactly on the ocular pathology desired and to obtain crisp, detailed photographs.

In our work with such powerful close-up lens utilized, the focusing mechanism on the camera has little effect, so we utilize a slight variation of the above technique. By setting the range-finder focusing ring at infinity, or 2.5 feet, one need only to move the whole camera back and forth until the image you desire is sharply focused. One may use either of the methods mentioned for determining focus, but I find the ground glass focusing the easiest for the extreme close-up pictures. Either may be used with equally good results.

Lighting.—The special supplementary lens requires that the strobe light be held in a particular position, as shown in Fig. 2B. The light is held close to and slightly above the light bracket on the camera with its housing directed down and in. Some mechanical difficulty will be noted when photographing the left eye, but it is easily remedied by shifting slightly lateralward. This allows the light to be directed correctly and adequately toward the eye. At this close range the strobe light reflex is larger, but if placed in the proper position as shown, the reflex falls off the eye and is not recorded at all in many cases.

Although the strobe light has a 70 degree field coverage, it is best to remove it from the camera with each exposure. On all but the very close pictures the light is held with the back of the lamp housing against the forehead immediately above the camera (Fig 2A). In this position the subject has a balanced illumination, producing a desirable three-dimensional effect. When taking the facial lesion from an oblique angle one may hold the light either above or to either side of the camera, depending on what effect you wish to obtain. If the lesion is laterally placed on the face with the camera positioned straight at the lesion, the light is held above the camera in the previously described manner. If the lesion is on the front of the face but the camera is oblique to the face, the light is held in front of the face. This maneuver illuminates the whole anterior face equally, plus the background.

Special effects may be produced by holding the strobe light in different positions about the face. With exophthalmous, or depression in the orbit and skull, you hold the light above and behind the leading edge of the afflicted area. This way the light casts a shadow downward outlining the pathologic area. Note how this technique amplifies the lid tumor, originally

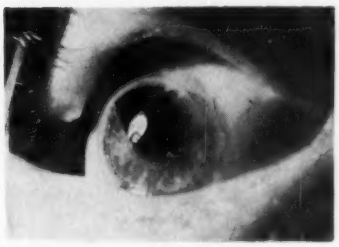

Fig. 8. Picture taken with special supplementary lens showing an anterior chamber cyst located at the 2:00 position.

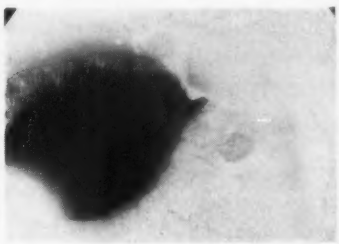

Fig. 9. Same as Figure 8 but the picture was taken through the Poser slit lamp and showing the epithelial cyst in the described location.

Fig. 10. This is the same lady as seen in Figure 7 but by the placing of the light above and slightly behind her one is able to bring out the presence of the upper medial lid tumor.

photographed the usual way as in Figure 7, as seen in Figure 10.

As long as you keep the strobe light as far away from the desired lesion as the camera is, you may move it about freely and get perfect exposures.

Patient Instructions.—The patient is told that an ordinary picture is going to be taken, and that a bright flash will be seen. With the strobe light so near patients frequently feel a flash of warmth with the light flash, so one may anticipate this reaction and explain it prior to exposure.

If you need the lids separated, the patient can do it for you, or your office nurse can assist you. Patients are most willing to help usually.

Fixation is easily achieved by having the patient look at your camera lens or at a suggested target.

Usually the patient is cooperative and the procedure takes little time. About one minute for three or four pictures.

One finds most children like to have pictures taken and cooperate well with few exceptions. Infants may have to be photographed after restraint is carried out by wrapping them in a sheet. Remember, movement does not affect your photo end-results.

Example Procedure

As an example, let us say you have a case you would like to photograph. A picture of a corneal lesion, for instance. Here is what you would do using this system.

Activate the strobe light (house current or batteries) and cock the shutter. Since you wish to photograph both eyes at first, place the .2M Proxar lens on the camera. The strobe "ready light" will be on now, signifying the unit is fully charged. Set the f-stop at 11, place the strobe light as directed with the lamp housing's back surface against your forehead, and grasp the camera as directed. Now, while viewing through the range finder, move in slowly toward the patient until the eyes are in perfect focus. Quickly trip the shutter at that instant and the picture is taken. Total time: about half a minute.

If you have the camera set up in the office with the .2M Proxar lens on, f-stop at 11, time at 1/250, and focus set at infinity you only need to activate the strobe light, focus, and snap the picture. It is very easily done.

Now to photograph just the involved eye, you remove the .2M Proxar lens and slip on the special supplementary lens. Here you have to make a special placement of the strobe light, as per diagram 2B, but you focus and make the exposure the same way. With the special supplementary lens one notes that a slight motion will bring the image to focus but also quickly throw it out of focus. Here is where the speed of the unit facilitates good pictures since you expose the picture while you are slowly moving in or out—and no blurred picture results.

Special Techniques

X-Ray Copying.—To copy x-rays, one need merely to put the x-ray on a fluorescent viewing box which is easily masked to the desired x-ray size using an ordinary desk blotter with the appropriate-sized hole cut from its center. Exposure is calculated for the area desired with a Weston meter and the exposure made. Usually it figures to about f4.0 to f5.6 at 1/30 second duration. The camera must be tripod supported here because of the relatively long exposure time.

Using the appropriate Proxar lens you merely select the field you desire to record and focus down on it. When utilizing this technique I find a .5M Proxar lens helpful also.

The final pictures are a light green color instead of the true bluish-white that x-rays really are, but we do not find it objectionable. With careful selection of the exposure, you can get good copies of x-rays without loss of fine tone definition.

Ideally you should use a pre-exposure technique. Details of the process are available from Eastman Kodak Co.

Slit Lamp Pictures.—In those cases where high magnification of a specific area is desirable, as in Fig. 9, the Contaflex may easily be adapted to fit the Bausch and Lomb Poser Slit Lamp. As a standard accessory, Zeiss produces a microscope adapter of two pieces. One piece is a large barrel designed to fit on the housing of the slit lamp ocular and the second is a ring adapting the camera to the barrel. Remove the slit lamp ocular, slip on the large microscope adapter piece and replace the ocular. Then attach the adapting ring to the camera and put the camera on the large barrel housing as per instructions. The whole assembly is moved forward so that the ocular tip just touches the camera lens mount assembly. Tightening the fixation screw on the assembly locks the camera to the eyepiece. Now by viewing through the camera one sees through the optics of the slit lamp.

Illumination for focusing is provided by the regu-

lar slit lamp illumination. By setting the focus at infinity one may get any part of the viewing field in focus by regulating the slit lamp focusing mechanism. To illuminate the field or film exposure the slit lamp light is moved to one side and the strobe light is held at the lateral canthus about 3 to 4 inches away from the eye. At this distance an f-stop of 4.0 or 2.8 will give correct exposure in a dark pigmented individual. Blue eyes, and light eyed individuals require f4.0 to f5.6.

Note that you do NOT photograph the beam slit using the technique.

35 mm. Transparency Copying.—By using the Special Supplementary lens one may copy other 35 mm. transparencies. The technique involves interposing the transparency you desire to copy between a light source and the camera. To obtain accurate color reproduction the film in the camera and the light source must be color temperature matched. This problem is easily solved by using Kodachrome type A film and a 375 watt photoflood light, both matched to 3400 degree Kelvin color temperature.

The light source is placed behind a 1-foot square wooden shield which has an opening in the bottom slightly larger than the actual film area of a 35 mm. slide. This shield allows light to come through the one hole only, and makes focusing much easier. To diffuse the light a small piece of plain white paper is placed over the light-side of the small opening. A fixation device holds the transparency at the desired position.

The Contaflex with the special supplementary lens on is placed in front of the transparency at the distance required to get perfect focus—approximately 75 mm. from the central anterior surface of the camera body (with the lens set at infinity). In this technique it is easiest to use the groundglass focusing system, but on occasion the rangefinder system is of advantage.

The Eastman Kodak Co. production-tests all Type A color film using 1/25 second exposure so it is best for one to utilize this shutter speed while copying. The variable here is the proximity of the light source to the transparency, i.e., the closer the source to the transparency the more light comes through. Using a Weston Master lightmeter's more sensitive cell, measure the light coming through the transparency—and move the light back and forth until you get enough light transmitted to require 1/30 second exposure. With a dark picture the light will come close to the transparency, and with a lighter picture it will be quite distant from it. So, get the transparency in focus, adjust the photoflood light to the proper distance, set the f-stop to the appropriate f-stop and expose. You may follow the procedure to make one or one hundred copies of the same picture.

This technique has the advantages of critical light control which allows you to improve over the original copy. The ones that are too dark you overexpose slightly to make the copy lighter, and vice versa for the light transparency. But the equipment is somewhat cumbersome, and hot due to the use of a photoflood light source.

At present, although we still use the above technique largely, we are developing a simplified technique utilizing the strobe light for a light source. It is our plan to have the light source fixed and have need only to vary the f-stop to obtain correct exposure.

Another advantage of a strobe light source is that one can use Daylight film which eliminates a need for switching films. One disadvantage with Kodachrome Type A is that it comes only in 36-exposure rolls. Daylight Type film comes either in the standard 20 or 36-exposure rolls.

Biopsy Photos.—Through the use of the three Proxar lenses and a blue, or green towel for background, you may easily and quickly photograph all your tissue specimens. If they are very small place on a clean microscope slide suspended by two wooden 1-inch square blocks off a blue background. Hold the strobe light about 6 inches away from your forehead but directed down toward the specimen. Set the camera at f11 or f16 and expose.

Summary

1. Presented is an ocular photographic technique of simplicity and accuracy.

2. This paper shows how one camera and supplementary equipment can be utilized to do multiple jobs in the ophthalmologist's practice.

3. It proves that non-specialized equipment can be utilized in producing good ocular photographs.

4. It shows that equipment which is not especially designed nor in need of any permanent modification, can be used in the system for producing ocular photographs.

The Human Electroretinogram

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THE HUMAN ELECTRORETINOGRAM is at present being studied in laboratories all over the world. The purpose of this paper is to relate to you the recent findings of the Electroretinography Laboratory in the Kresge Eye Institute. The laboratory is presently beginning its fifth year of activity and to date more than 500 patients have been tested, many of them more than once and some seven or eight times.

At the same time we wish to reiterate and re-emphasize the clinical value of the electroretinogram (ERG) and to point out its potential use in the everyday diagnostic armamentarium of the ophthalmologist. Objective tests of function are rare, more important. Modern medicine has placed more and more stress on the prevention of disease which has made the objective evaluation of function necessary. All of us are aware of the many electronic tools which have come along to take part in the determination of physiologic processes. Among these is the subject for discussion, namely the appartus and procedure used for determining the electrical potential of the retina as stimulated by light.

There are sceptics who point out that the electrical potential evolving from the retinal stimulation by light, is actually the result of diffuse light entering the eye, in essence a mass response. It is then pointed out that the response is too complex to determine a particular retinal defect, especially central, or to localize an area of diminished function. Since the presently utilized light sources cannot be focused accurately, this mass response is felt to be inadequate to the needs of the clinician who must have a specific test for a specific part.

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Here the discusser would take issue with the above. First, even though the response is a result of the mass stimulus, previous observers have been able to break the ERG into rather clear-cut component parts. For instance, the a-wave is believed to be a result of change in potential in the area around the outer limbs of the visual cell. The b-wave is a result of change in potential in the area of the inner limb of the visual cell and the bipolar cell. The c-wave, a potential change occurring in the area of the pigment epithelium. Early investigators have noted that certain stimuli cause a response from the retina which may be due to photopic or scotopic processes, e.g., the response to colored light and the response to a flickering light apparently indicate photopic responsiveness.

Some of these determinations have evolved from repeated and careful investigation of animals utilizing the response from a single cell or the response obtained after cells have been poisoned by specific metabolic agents. Repeated examination by various observers on human subjects tend to bear out and strengthen the experimental findings. It is not necessary to repeat once more our feeling that the electroretinogram can be used as a clinical tool, utilizing experimental conditions. Suffice it to say that we follow a standard procedure for each patient so that normal and abnormal cases can be compared readily and the results obtained subjected to standard statistical evaluation.

In our laboratory, at the present time various procedures for the evaluation of the electroretinogram are under way. First, let me say that with the present testing conditions and equipment, it would appear that we are able to get reproducible results from the same patient at different times so long as retinal function is constant. Comparable electroretinographic results may be obtained regardless of whether portable or fixed equipment is utilized.

The data from our series of cases involving the posterior central retina are presently undergoing statistical evaluation. From the cases evaluated to date, as compared to known normal individuals there is no doubt that the electroretinogram in those patients with posterior central involvement of the retina is consistently abnormal. To date we have evaluated cases of hereditary juvenile and adult central pigmentary degeneration, Kuhnt-Junius disease with or without pseudo-xanthoma elasticum, senile macular disease, uveitis involving the posterior central retina, and central and peripheral visual cell degeneration.

Before final statistical evaluation, the results to date would indicate that with unilateral or bilateral posterior central disease there is a reduction in the electroretinogram from normal levels, there is a general slowing and flattening of the components of the a-wave, there is a reduction in the response to red light, and a reduction in the response to the flickering light. The clinical impression of a centrally located lesion is not well borne out by the ERG. For example, our cases of angioid streaks without central involvement have abnormal ERGs. As the disease progresses the ERG becomes worse.

We are also going to evaluate a series of normal patients at repeated intervals under various external conditions and times utilizing both fixed and portable equipment. We are going to subject the response to a flickering light to Fourier analysis which should allow us a more sophisticated evaluation of the character and parts of the flicker response.

We are at present constructing an ERG apparatus utilizing principles recently set forth by Armington.[1] In essence, this consists of a totally computorized ERG system which allows the evaluation of a very low intensity stimulus upon the retina. The technique is similar to that utilized in recovering electronic stimuli from the various satellites coursing through space.

On the basis of studies performed in the laboratory on patients ranging from five to eighty-five years of age and on whom adequate examinations and re-examination could be performed, we feel that the electroretinogram is of clinical value in the following circumstances:

1. Differential Diagnosis.
   A. An optic nerve from a non-optic nerve disease
   B. Visual cell damage: (1) Peripheral from central retinal degeneration. (2) Peripheral and central retinal degeneration

2. Diagnosis—congenital stationary night blindness, retinitis pigmentosa, congenital amblyopia on the basis of total visual cell degeneration, unilateral versus bilateral disease.

3. Objective evaluation of the progress of a disease, e.g., retinitis pigmentosa.

4. Recognition of an otherwise unsuspected disease process of the retina; for instance, unexplained amblyopia in a young child, or an adult for that matter.

5. The evaluation of a hereditary visual cell degeneration. In the future we must consider the possible utilization of tests which reveal potential weakness in cell function. Since many of the hereditary visual cell degenerations begin in young prereasoning children, the objective test for function becomes a necessary implement to diagnosis.

6. Retinal detachment. Evaluation of retinal function in retinal detachment has been interesting from several points of view. In the first place, retinal function in the unaffected eye is often markedly reduced. The possibility of determining a critical retinal function level prior to physical retinal change must be considered. Also, the poor retinal function noted in many severe cases of retinal detachment and the number of cases which show real improvement in the ERG following maximum surgical intervention makes one more anxious than ever to determine the earliest detachment situation in order to prevent the serious progress of the disease. The studies on retinal detachment are still in progress and a final conclusion can not be discussed at this time.

7. Comparison of function in both eyes in a monocular or binocular disease.

In a period of over four years of active investigation of various retinal diseases by electroretinographic technique, this observer is more enthusiastic than ever over the potential diagnostic function of this tool in ophthalmologic disease.

Reference

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Indications for the Removal of Cataract

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IT MAY SEEM OBVIOUS that cataracts should be removed when their presence interferes with vision but, because of possible complications, both organic and psychologic, associated with cataract extractions, optimal conditions should be determined for such surgery. Let us consider some of these conditions:

Cataract in Adults

Unilateral Cataract.—When one lens is clear and the vision good in that eye, the general rule holds (the exception will be discussed below) that the cataractous eye should not be operated, no matter how reduced the visual acuity. The reason for this is that the patient will still continue to use the noncataractous eye and begin to doubt the purpose of the operation since he still cannot use the operated eye. Verbal explanation as to the inability to use both eyes together after operation to remove one cataract is not usually understood before experience makes this reality manifest.

However, there are some special situations in which unilateral cataract extraction is reasonable and indicated. These are (a) traumatic cataract in which either an experimental anterior chamber lens or a contact lens is planned, (b) swollen or hypermature cataract, (c) where, for cosmetic reasons, the patient desires the cataract removal, and (d) in industrial situations where the presence of the cataract is a hindrance to employment. Involvement of the visual field is sometimes used as a reason for lens extraction in monocular cases. Often, the patient does not realize or appreciate the advantage obtained.

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Traumatic Cataract: When the onset of traumatic cataract was before the age of seven or eight, one must suspect the possibility of amblyopia when dealing with the patient when he is examined at a later age. If the injury has occurred after seven or eight, a contact lens or an anterior chamber lens (still experimental) may be effective in giving binocular vision.

Unless surgery is necessary within a short time after injury, the eye should be free of any inflammatory signs for a year before elective surgery is considered.

Unilateral Swollen or Hypermature Cataract is an indication for surgery to prevent both the formation of spontaneous capsular dehiscenses and phakolytic or secondary angle-closure glaucoma. It may be helpful in these cases to give a lateral field of vision for security reasons.

Industrial Situations: When unilateral cataract is removed for industrial reasons, the correction is given with a regular cataract lens for the operated eye and the usual correction for the unoperated eye. This produces diplopia, but the glasses are used only to pass the visual tests since most industrial examiners are interested, not in binocularity, but in the corrected vision with each eye.

Bilateral Cataract, Incipient in One Eye and Advanced in the Second.—

Incipient Cataract in the second eye is an indication for surgical removal of the cataract in the first eye if the vision in the second eye is somewhat reduced, perhaps to 20/30 or less. This brings up the question of the visual acuity as a measure of the indication for cataract extraction. It is obvious that when the visual acuity measurement in each eye is 20/50 or less, usually 20/70 or less, that cataract extraction in one

From the Sinai Hospital of Detroit and Wayne State University College of Medicine.

eye is indicated, yet there are cases with 20/25 acuity in each eye and inability to carry on one's visual activities for near distances. · Cataract extraction should be done in such cases to follow out the axiom that cataract extraction is indicated when the lenticular opacity interferes with the carrying out of the usual visual functions for the individual. One should keep in mind that a patient with bilateral central posterior subcapsular cataracts may be unable to see at all clearly in bright light but when the patient is measured behind the refractor, the pupils dilate in the subdued light and the visual acuity is much better than under outdoor conditions.

A very important factor in the decision as to surgery in bilateral cataract cases is the determination of the status of the retina and optic nerve. When one eye has only an incipient opacity the status of the fundus of the more densely cataractous eye can be inferred from the one more easily studied. In cases where both lenses are moderately opaque, the use of the Schepens binocular indirect ophthalmoscope makes possible a view of the fundus which is impossible with the direct ophthalmoscope. In cases of retinal detachment with cataract, the cataract may be removed to permit visibility of the fundus.

Age is not a contraindication to cataract surgery.

Cataract in Severely Damaged Eyes.—This may be an indication for extraction if there are the same indications as discussed above and if the patient is totally blind. The one requirement is the perception of light and some projection. Even poor projection is sometimes followed by good vision after extraction of a very opaque lens. The eye should be quiet. Even band opacity of the cornea may not be a contraindication as is shown by the following case history.

History of Case

H. F., Polish refugee woman, aged thirty-eight, was seen on June 17, 1957. She gave a history of a severe uveitis in both eyes twelve to fourteen years previously. Vision was hand movements right and finger-counting at 6 inches left. Bilateral cateracts and old posterior synechias were present. A band opacity was present on the right cornea. This was treated with 1 per cent hydrochloric acid after removal of the epithelium. This healed quickly, leaving a clear cornea. On June 25, 1957 an intracapsular cataract extraction was done on the right eye. After uneventful healing the right vision was 20/50 with +2.25 +2.00 x 105. The fundus showed myopic degenerative changes. On November 6, 1958 a left intracapsular extraction was done. The corrected vision after healing was 20/400 with +4.00 +1.25 x 110. Myopic changes involved the macula more than on the right. However, the patient was able to carry on independent normal activities as a housewife.

Some of the eyes in this category may have a completely fluid vitreous and no hyaloid membrane so that the lens is held to the iris by posterior synechias. In such eyes severely damaged by old uveitis, it is wise to avoid breaking all the synechias before application of the erisiphake or capsule forceps.

Cataract in the Presence of Mild Chronic Cyclitis as in heterochromic cyclitis may be extracted in the usual manner, with the same indications. Corticosteroids are used before the operation and during the postoperative period.

Nuclear Sclerosis in Highly Myopic Eyes gives a special situation in relation to reading. This has not had sufficient attention in the literature. Such patients with about —20.00 myopia with considerable myopic macular degeneration may still be able to read by removing glasses and holding the reading matter close. If both crystalline lenses are removed, the patient, even with correcting lenses, cannot read. I have in one such case operated on one eye to produce better distance vision with slight correction but the patient had to use the cataractous eye to read with. This inability to read after cataract extraction in such a case indicates that surgery should be postponed until the opacity is so advanced that the patient cannot read without glasses at a close distance.

One-Eyed Patients with Cataract.—When cataract is present in a one-eyed patient it is best to postpone surgery until the patient has "nothing to lose and everything to gain," in other words, until the visual acuity is reduced markedly and the patient requests surgery.

Hypermature Cataract with Glaucoma Due to Angle-Closure or to Phakolytic Factors.—Where the cataract is responsible for the glaucoma, the lens should be removed immediately.

Congenital Cataract

The goal of cataract extraction in children is the same as in adults but the achievement of this goal is more difficult in children. In addition to the indications we must consider the optimum time and type of surgery.

When *monocular* cataract is present from birth, it is best to avoid surgery unless hypermaturity or cosmetic reasons are present. Surgery should then be done as late in childhood as possible. If the eyes are straight and the unilateral immature cataract is removed, the

eye may later cross and the surgeon be held responsible. These eyes are usually amblyopic.

In *bilateral* cataracts, surgery should not be done if the vision is 20/50 or better. Some zonular cataracts which appear to be quite opaque give as much as 20/30 or 20/40 vision and should therefore not be operated before 4 years of age. If there is doubt as to whether the patient has enough vision to get along with, the operation should be defered to 5 or 7 years of age when the vision can be tested better.

The timing of indicated surgery is important. It should be done when anesthesia is easiest. Usually the cooperation of the child cannot be expected, so special techniques are necessary. In complete or nearly complete cataracts I consider three to six months of age as early enough for surgery and that surgery is certainly to be done before school age. Usually one eye is done early and, if all goes well, the other eye is done. Otherwise, one should wait until about two years of age. Remember that in most cases there is amblyopia in one eye and this should be anticipated.

Type of Operation

In infants with complete or nearly complete cataracts, the operation of choice is either needling or, preferably, needling followed in a week by linear extraction with complete iridectomy and, if desired, inferior sphincterotomy. The inferior spincterotomy is done with a blunt scissors after doing the iridectomy. Preliminary massage of the globe is indicated.

In cataracts with liquefied cortex, either spontaneous or following needling, the Fuchs two-way syringe is an ideal method for removal of lens material. It contains a double channelled tube which simultaneously injects fluid through one channel while sucking up substances through the second. These methods are preferable to repeated needlings following which, in some cases, retinal detachment occurs, even many years later. In these cases preliminary iridectomy and capsulectomy are necessary before the detachment surgery. In some even this is not adequate to permit proper visualization.

In using the capsulectomy forceps in linear extraction, one should apply it only once to prevent getting too deeply. In cases where the capsulectomy forceps does not work, one should continue holding the capsule forceps in place and use the cystotome with the other hand. Only gentle stroking on the lower cornea should be used in expressing the lens material. Atropine should be used for at least a month after the eye is quiet.

28 W. Adams

Tells Conference

Director Angus Campbell of U-M Survey Research Center, told the U-M Conference on Aging that:

"Older people are clearly more inclined than younger people to favor government help in getting medical and hospital care at low cost and to approve governmental responsibility for full employment.

"They are slightly more likely to approve a program of public power and public housing. They are no more likely, however, to favor a Fair Employment Practices Commission-type legislation or public aid to education than are young people.

"Attitudes on these welfare issues among the aged are based largely on economic self-interest, not on political ideology.

"While those 65 and over favor federal aid in getting hospital and medical care at low cost, they are the strongest of all age groups in favor of cutting taxes. Similar combinations of attitudes have been found repeatedly in the Center's studies."

Topical Use of Ismelin

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SOME CLINICAL AND EXPERIMENTAL evidence suggests that primary glaucoma may result from disturbance of the balance between the sympathetic and parasympathetic systems, leading to a preponderance of the sympathetic.[1-4] Re-establishment of a normal balance between these systems seems possible by the use of drugs which would strengthen the parasympathetic or weaken the sympathetic stimuli. An attempt was made to do this with different sympatholytic compounds. Of the sympatholytic drugs, ergotamine, other derivatives of *Secale cornutum*, and dibenamine have been most often used.

Ergotamine was used systemically. Some pressure-lowering effect was observed in eyes suffering from one of the congestive forms of glaucoma. In addition, some enhancement of the pressure-reducing action of pilocarpine was noted. These effects were not marked and became even less so after a few days of use. Thereafter the results became contradictory and side-effects were so consistent that ergotamine nearly completely disappeared from use in glaucoma therapy.

Dibenamine, the second important sympatholytic drug, was especially recommended before the introduction of the carbonic anhydrase inhibitors because this compound, which acted as a miotic, reduced the formation of humor aqueous and was able to lower the pressure in the eye. The results were often contradictory and seldom satisfactory and side-effects (especially orthostatic hypotension) so important when administered systemically, that it was tried as a topical application. No effect whatever on eye pressure was observed when instilled, so the drug was abandoned in glaucoma therapy.

Guanethidine (Ismelin®) acts at the terminals of the sympathetic nervous system, without affecting the parasympathetic system. It blocks the sympathetic impulse by intervention at the myoneural junctions.

Keates and his associates[5] used Ismelin intravenously and observed the lowering of intraocular pressure in normal and glaucomatous eyes, especially in chronic simple glaucoma. Untoward side-effects, especially the action in lowering blood pressure when administered systemically, hindered the use of this drug in glaucoma for a longer time.

The drug used in this study is a 10 per cent concentration of the (full) sulfate of guanethidine buffered to pH of 6.1 for topical use, supplied by the Ciba Company. One drop of Ismelin was instilled into the conjunctival sacs of four rabbits at one-minute intervals for a period of five minutes. The intraocular pressure was measured after five minutes and then every fifteen minutes for one hour. No effect on pressure could be observed. No significant effect on pupil size was evident. A slight hyperemia of conjunctiva was noted. The effect of Ismelin on the intraocular pressure and pupil size was studied on fourteen patients with elevated intraocular pressure, eleven with dark irides and three with blue. Instillation of one drop of Ismelin at one-minute intervals for five minutes was made. The tension was measured after five minutes and every fifteen minutes for one hour. No significant effect on pressure was evident. No measurable modification of pupil size was found.

In an attempt to check its sympatholytic action, Ismelin was used in combination with pilocarpine, cocaine, and atropine. It was considered that Ismelin might enhance the pressure-lowering effect of pilocarpine, but no difference was found between the action of combined Ismelin and pilocarpine and pilocarpine alone. One might expect that if Ismelin were used before instilling cocaine, the sympathetic block would decrease the mydriatic effect of cocaine. The sympathomimetic effect of cocaine is achieved by sensitizing the muscle cells to sympathin. No difference in the size of pupils was found when Ismelin was instilled into one eye and later cocaine was instilled into both. In two patients pretreated with Ismelin drops in one eye, the subsequent instillation of atropine into

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Ismelin® is a Registered Trademark of Ciba Pharmaceutical Products, Inc., Summit, New Jersey.

both eyes showed no significant difference in the amount of mydriasis.

In three patients with bilateral chronic simple glaucoma with dark irides, Ismelin was given subconjunctivally in one eye and 4 per cent pilocarpine drops were used in the other eye. In two instances, no pressure-reducing effect of Ismelin was evident, although the intraocular pressure was normalized in the eyes receiving the pilocarpine. In the third patient (one with tensions of 30 mm. Hg right and 46 mm. Hg left), the tension after one hour was 21 mm. Hg in both eyes. In all three patients who received Ismelin subconjunctivally, a slight mydriatic effect of about 2 mm. was evident.

No significant pressure-lowering effect or sympathetic-blocking effect on the pupil could be observed following topical administration of Ismelin.

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Glaucoma

Influence on Cyclogyl and Neosynephrine on Tonographic Studies of Miotic Control in Open-Angle Glaucoma

The work reported compares the tonographic effects of cyclopentolate (Cyclogyl) a parasympatholytic drug, and phenylephrine (Neosynephrine), a sympathomimetic drug, on the intraocular pressure and facility of outflow in eyes under miotic therapy for open-angle glaucoma. Tonographic studies were made on 17 eyes in 9 patients with open-angle glaucoma controlled on various forms of miotic therapy. Tonographic studies were performed during miotic therapy alone, during miotic therapy with Neosynephrine added, and during miotic therapy with Cyclogyl added. Addition of Neosynephrine to the miotic therapy had no consistent effect on the intraocular pressure or tonographic facility of outflow. Addition of Cyclogyl to the miotic therapy usually resulted in an increase in the intraocular pressure over that with miotic therapy alone, and a decrease in the tonographic facility of outflow in every case tested. The fact that mydriasis with Neosynephrine usually does not elevate the intraocular pressure and does not consistently reduce the facility of outflow in open-angle glaucoma (1) allows for its use as an aid in the differentiation of narrow-angle vs. open-angle glaucoma, (2) permits its safe use as a mydriatic for fundus examination in open-angle glaucoma, and (3) points up the fact that the controlling effect of miotics in open-angle glaucoma is not related to pupillary size. On the other hand, use of Cyclogyl (and probably cycloplegics in general) should require more caution in patients with open-angle glaucoma, as the facility of outflow is decreased with Cyclogyl even if the condition is controlled on miotic therapy.—R. A. SCHIMEK and W. J. LIEBERMAN, Amer. J. Ophthal., 51:781 (May, Pt. I) 1961.

Prognosis of Secondary Glaucoma Following Retinal Artery Occlusion with Report of an Interesting Case

Secondary glaucoma following central retinal artery occlusion is a distinct clinicopathologic entity. Approximately four-fifths of eyes affected with this condition were surgically enucleated, according to reports in the literature. The remainder—with the improbable exception of 2—had no light perception. The outcome of treatment has been universally unsuccessful. A case was presented in which there was a central retinal artery occlusion with macular sparing due to a unilateral cilioretinal artery. A second catastrophe was then visited upon the "spared" eye in the form of a secondary glaucoma, the prognosis of which type of glaucoma has been universally and extremely bad. Treatment was surgical and medical. To date, the affected eye still retains useful central vision.—D. I. WEISS and I. H. LEOPOLD, Amer. J. Ophthal, 51:793 (May, Pt. I) 1961.

The Role of Alpha-Chymotrypsin In Ophthalmology

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SINCE Barraquer's address[1] on "Enzymatic Zonulolysis" before the 65th Congress of the French Ophthalmological Society in Paris, May, 1958, there has been a rash of papers published dealing with all phases of cataract extraction with alpha-chymotrypsin.

Discussions on cataract extraction always have been popular, but of late they have been largely rehashes of former discussions because of the paucity of new interesting material. The use of the enzymes has provided the impetus for renewed interest and experimentation.

The discovery of the usefulness of alpha-chymotrypsin in cataract extraction presents an interesting story, illustrating how history repeats itself. In a recent editorial in the *Archives of Ophthalmology*, Dave Cogan[2] wrote:

> Like the argument as to who discovered the usefulness of ether, we (now) have the same problem as to who first used trypsin in cataract extraction.
>
> Crawford Long of Jefferson, Georgia, probably was the first to use ether for anesthesia, but failed to report it. Morton, a Boston dentist, rediscovered it and this was reported (by him) in the literature.
>
> Dr. Ben Jenkins of Georgia began using alpha-chymotrypsin for zonulolysis in 1955. An attempt to clear vitreous opacities in a congenitally blind eye was unsuccessful, but the enzyme did cause the lens to dislocate. Jenkins then routinely used the enzyme for cataract extraction but failed to report it in the literature.
>
> Two years later, Dr. Joaquin Barraquer (of Barcelona, Spain) made a similar observation. With the hope of dissolving a vitreous hemorrhage he injected alpha-chymotrypsin into an eye. No effect was noted on the hemorrhage, but the lens dislocated and Barraquer began using it in his cataract cases. He reported it in the literature in 1958.

Undoubtedly Barraquer and Jenkins will go down in history as co-discoverers of alpha-chymotrypsin as a zonulolytic agent just as Morton and Long were the co-discoverers of ether as an anesthetic agent. We will let the historians wrangle over priorities.

The clearest concept of what the enzyme does to the zonules has been offered by Ley and associates.[3] They employed light and the electron microscope to show that the enzyme apparently lysed certain segmental zones across the zonular fiber so that it was fragmented into many short sections. Just how these segmented zones differ from the rest of the fiber is yet to be elucidated.

Barraquer,[1] in his original report, stated that the enzyme has a specific action on the zonule and nothing else. There are numerous references in the literature that cast doubt on the "specific action." Lytic action on the vitreous body and retina have been reported. Many feel very definitely that wound healing is delayed and that catgut sutures are dissolved more quickly when it is used. On the other side of the fence are those firmly denying these allegations. Whatever its action, all agree that it facilitates lens extraction and, when used as indicated, minimizes complications and gives a higher percentage of intracapsular extractions.

There are several products on the market at the present time which all seem to be equally effective. The author personally could not tell when any particular product was used either in its effectiveness or

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after-effects. The main concern has been in its sterility and freedom from foreign matter. A tendency has been noted for operating room personnel to handle the vial containing the diluent in the same non-sterile manner used for extracting local anesthetic agents and so forth. They simply wipe off the glass vial or rubber stopper with an alcohol sponge before breaking the neck of the vial or inserting the needle to withdraw the diluent. These vials should be soaked in the surgeon's favorite sterilizing solution used to sterilize sharp instruments, then the vial should be considered a sterile container.

A difference of opinion still exists as to when trypsin should and should not be used, and it must be admitted that sufficient time has not elapsed for firm opinions to be formulated. In an attempt to arrive at some conclusions in this regard, the investigator used alpha-chymotrypsin routinely for 224 cataract extractions. When the series ended, certain impressions were evident, the foremost of which was that it was not indicated in routine cataract extractions and second, that residents should not use it until they have familiarized themselves with usual techniques.

The youngest patient in which alpha-chymotrypsin was used in the series was 25 years old. The author and his associates, as well as others, feel that cataract extraction in those patients between twenty-five and sixty years of age is more easily executed and with a higher percentage of intact capsules than without it. Beyond sixty years of age it could not be said with any certainty that alpha-chymotrypsin was of any additional value. Since most cataracts are removed in individuals over sixty years of age, its use now is infrequent. There is so much variation in the resistance offered by the zonule in those of sixty years and over that, in the investigator's area, trypsin is being used in this age group only if the first eye has tough zonule.

Intumescent and hypermature cataracts have always been difficult for the author to extract with forceps; frequently the capsule is broken even with the erisophake. It was found that alpha-chymotrypsin made the extraction in both entities easier with a higher percentage of intact capsules.

Alpha-chymotrypsin is avoided in cases where hypotony is not obtained by retrobulbar injection, because the lens so often becomes spherical and practically delivers itself expulsively in these cases. This product is not utilized in high myopia, postoperative retinal separation, uveitis and traumatic luxation of the lens with vitreous face ruptured, because of the suspicion that the vitreous is more or less fluid in these cases. The author and his associates have not had enough experience with the luxated lens of Marfan's syndrome to give a firm opinion. It is believed, however, that the possibilities of complications are greater when the enzyme is not used.

It is the opinion of the investigator and associates that preliminary needling followed by linear extraction to be the safest technique under 25 years of age. It is true that by this method two and sometimes three operations are required to get the final visual result, but the author as yet cannot forget the movie presented at the Academy by Richard Troutman two years ago showing the attachment of the vitreous to the posterior surface of the lens and the extraction of both when alpha-chymotrypsin was used in this young age group.

From the author's series of alpha-chymotrypsin extractions, it was learned that new techniques had to be acquired. It was noted that although it made the delivery of the lens easier, the author still had to use the products of experience with regular lens extraction (particularly that of the luxated lens) to do an effective job. It was because of this need for judgment and skill acquired by experience that it was decided that the residents should not start out using this product, but its use was limited to the latter part of their surgical training and then only in selected cases.

It was found necessary to have a widely dilated pupil and if this could not be acquired by injecting epinephrine (1/1000) in the sub-Tenon' space about the limbus and instillation into the anterior chamber, a sphincterotomy would be done above. The author can see no need to do a broad based complete iridectomy in the non-complicated eye.

There is a difference of opinion as to whether 1/5000 or 1/10,000 dilution of alpha-chymotrypsin is most desirable. Except for the first fifteen eyes in the author's series, a 1/10,000 dilution was utilized and left in contact with the zonule for three minutes before the chamber was irrigated with saline.

The amount of trypsin injected into the posterior chamber varies with different authors. The posterior chamber holds only 0.3-0.5 ml. of aqueous, and it is the investigator's practice to inject through the peripheral coloboma above until the iris balloons forward and the solution then comes out of the incision; it is then known that there is trypsin in all parts of the posterior chamber. Some surgeons feel that by injecting through the pupil and into the lower half of

the posterior chamber they are able to cause lysis of the lower zonule only and thus reserve the upper zonule intact as a hinge for tumbling. This sounds good in theory but in practice it is difficult to control the area of zonulolysis by this method. Hill[4] advises Kato's[5] method of injecting only two drops of alpha-chymotrypsin below if you intend to retain a hinge of zonule above for tumbling.

Tumbling of the lens is dangerous unless the zonular attachments are retained above. The sliding technique is certainly indicated with full luxation of the lens. There is a strong tendency for the lens to assume a spherical shape and to push forward with the iris rather snugly against the cornea. This tendency is less when the degree of sclerosis present is greater. When the lens assumes a spherical shape it was found difficult to grasp the capsule with the capsule forceps and the erisophake had to be used.

The forward position of the lens makes it difficult and dangerous to get even the erisophake on the capsule below for tumbling without injuring the corneal endothelium. Murphy[6] attempts to correct this handicap by applying the erisophake immediately after injecting the enzyme and holding it there for the three minutes needed to effect zonulolysis. The author has not tried this method, but it sounds as if it would be necessary to pre-guess which lens was going to come forward to make this seemingly clumsy maneuver necessary. The author could hardly see himself hanging onto an erisophake for three minutes. There are too many times when the Bell erisophake loses its grasp, also too much opportunity for accidental movement on the part of the patient or surgeon during this waiting period.

The forward position of the spherical lens, when it occurs, is an indication for the surgeon to slide the lens out by pressure below and possibly a flat spatula above, very similar to the old Smith-Indian technique. No instrument is applied to the lens itself. When the lens doesn't come forward strongly, the cornea can be picked up and erisophake applied above and lens slid out.

In the literature are recurring references to impressions that alpha-chymotrypsin caused: (1) Catgut sutures to dissolve more quickly; the author's group did not find this to be true; (2) that wound healing was delayed and therefore indicated the use of at least five corneoscleral sutures, preferably silk. The author and associates have not found any evidence of delayed wound healing or the need for more than three gut corneoscleral sutures; (3) that alpha-chymotrypsin should not be utilized if there is endothelial corneal dystrophy. The author personally feels that endothelial corneal dystrophy is one of the indications for alpha-chymotrypsin, since its use makes the lens delivery less traumatic and anything which will do this will be less damaging to already damaged tissues. Certainly, there was no evidence that the enzyme was producing corneal edema or damage. Hill[4] noted less striate keratitis with the use of alpha-chymotrypsin—another indication that the cornea is treated more gently by its use, especially when the sliding technique is used. Admittedly, the tumbling technique should not be utilized in any case of corneal dystrophy whether trypsin is used or not.

The author's group is now collecting data in the hope that some information will evolve referable to the incidence of anterior hyaloid rupture at operation or at various times postoperatively in an effort to see whether trypsin has any influence in its production. A similar interest in postoperative retinal separation is being exhibited in this regard but the information is not yet available. In both conditions there are so many other factors involved in their production that an answer may not be forthcoming.

Iris pigment epithelium fragmentation with liberation of black pigment in the aqueous almost immediately with the injection of alpha-chymotrypsin has been noted by Kara.[7] The author has not been able to relate this to the injection and yet it does occur with or without trypsin in cases of iris atrophy, notably in association with diabetes. It is prone to be deposited on the corneal endothelium and often is not seen, especially in the pupil area, until the chamber is filled with air or saline. Most certainly the only time that it can be removed is at the time of its deposition and this by irrigation.

The author has not seen corneal edema with alpha-chymotrypsin as reported by Kara.[7] The latter, however, stated that he saw corneal edema and pigment epithelium fragmentation mostly with the Spanish product (Penya). This product was used exclusively by the author's group until the Armour product became available. Murphy[6] also noted marked corneal edema and striate keratitis with alpha-chymotrypsin, but it cleared in most cases in ten days but persisted in a few others for four weeks. He used 1/5000 dilution which might be a contributing factor. He also reported more vitreous loss, iris prolapse, hyphemia, retinal separation and endophthalmitis than in a similar series when trypsin was not used. The series of the author and his associates does not sub-

stantiate these serious objections to its use. On the plus side, Murphy[6] found less frequently loss of anterior chamber and fewer ruptured capsules with alpha-chymotrypsin. The latter finding is almost universally noted in reported series.

What, then, can be said referable to experience with alpha-chymotrypsin by the author and his associates?

1. Reserve the enzyme for those eyes in which difficulty is anticipated in getting an intracapsular extraction in the 25-60 year old group.

2. A preliminary needling followed by linear extraction is as yet preferable to alpha-chymotrypsin in the age group under 25 years; over 60 years of age there is little if any help obtained from trypsin.

3. It is necessary to learn to use an erisophake as it is more frequently needed with alpha-chymotrypsin than without.

4. The sliding technique is the least traumatic with alpha-chymotrypsin.

5. Alpha-chymotrypsin is advisable in intumescent and hypermature lenses and in cases of exfoliation of the lens capsule, in all of which capsules are prone to rupture.

6. Alpha-chymotrypsin is indicated, in the investigator's opinion, in endothelial corneal dystrophy along with the sliding technique as the least traumatic operation possible.

7. Alpha-chymotrypsin is helpful in traumatic and congenital luxation of lens with intact hyaloid.

8. Alpha-chymotrypsin is contraindicated in luxated lenses with vitreous face ruptured and in cases of known or suspected fluid vitreous.

9. *Amen* is said to P. J. Kennedy's statement[8]:

Although trypsin is a valuable aid in obtaining an intracapsular extraction—in certain instances, its use does not minimize the knowledge, skill and manual dexterity which are necessary for good surgery.

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Hospital Construction Report

Last year in the United States an average of $2.7 million a day was spent on the construction of hospitals, nursing homes and other health facilities.

A total of $978 million was expended on such construction during 1960, based on statistics supplied by the U.S. Department of Commerce.

The past five years were a peak period for hospital construction. From 1956 through 1960, expenditures on new construction of hospitals, nursing homes and other health facilities amounted to $4,467,000,000, compared to $3,866,000,000 for the preceding five-year period.

Other government analyses have shown that private sources now provide the major portion of the funds for this construction.

In 1940, total hospital construction expenditures were $87 million of which $33 million, or 38 per cent of the total, came from private sources. However, in 1960, private construction amounted to $579 million, or 59 per cent of the year's total of $978 million.

Contact Lenses and the Medical Profession

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THE FIRST CONTACT LENSES were developed by medical practitioners. These were made of glass and used for corneal astigmatism. These lenses were extremely uncomfortable, causing pain and corneal edema after several hours of wearing. Over a period of years the lenses evolved from a molded scleral shell with fluid filling the space between cornea and lens to a lens allowing tear interchange between the cul de sacs and lens by holes made in the lens; finally evolving to the various types of small corneal lenses utilized today. Most of the advances made were due to the utilization of monomer-polymer mixes or polymethyl methacrylates which are clear, relatively inert when properly treated, and easy to work.

Actually, much of the evolution from scleral to corneal lens was a result of work by lay individuals or groups. Their primary purpose was to develop a lens utilizable to larger, non-medically oriented people; in other words, a lens which could be worn by individuals who desired only such cosmetic improvement as could be achieved by discarding spectacles.

The development of the corneal lens was accompanied by flamboyant advertising in the public press which readily drowned out the disclaiming cries of the medical profession.

From the time of the introduction of corneal contact lenses (at the end of World War II), to the present there have been serious objections to the indiscriminate wearing of contact lenses by the general public. In essence, the medical objections are as follows:

Lack of Understanding of Corneal Metabolism.—To this day practically nothing is known of the corneal function with a contact lens (of any type) in place.

Lack of Uniformity of Standards and Nomenclature.—There are many manufacturers of contact lenses, each claiming their product is best. The lack of uniformity in discussing details of structure, nomenclature, and even units of measurements, e.g., millimeters vs. inches, is appalling.

Materials.—The standard material used in the manufacture of contact lenses is methyl methacrylate. This substance is a monomer-polymer mix and can be severely irritating to living tissue generally depending upon the amount of monomer left in the stock used for grinding the lens. Naturally, the stock varies with the manufacturer. Methacrylates are also notable in their porosity and hygroscopic action. Both features tend to increase the irritability of the finished lens by causing stickiness of the lens to the tissues and by washing more of the monomer out of the lens as well as taking on fluids, either of which are not easily tolerated by ocular tissues. The easily scratched surface of this plastic is another feature which reduces the functional characteristics of these lenses.

Medical Ethics and Understanding.—This is the area where the gentlemanly relationships between the medical profession and various lay groups may be strained to the breaking point.

Advertising in the public press.

Failure to evaluate the potential contact lens wearer from a medical point of view: The contact lens is a prosthetic device. Unless the patient is carefully evaluated from a medical point of view as to the need of contact lenses or their desirability, serious ophthalmologic disease, such as glaucoma, may be overlooked.

Use of drugs: It is a matter of public law that drugs are a province of medical practice. Yet it is also known that various lay practitioners of contact lens fitting are routinely using such drugs as fluorescein and local anesthetics without medical supervi-

sion. As a matter of fact, contact lenses can not be fitted without using drugs.

Diagnosis and treatment of medical complications of contact lenses: The increasing popularity of contact lenses naturally has increased the complications which can occur as a result of their use. The reasons for this are obvious: lack of suitability; improper fit; lack of knowledge of corneal metabolism; poor training of the patient as to insertion, removal, hygiene and wearing time; secondary trauma; infection; lack of supervision; etc.

If medical care is not readily available, permanent damage to the cornea, and possibly the globe, may result.

Increasing knowledge of medical uses for contact lenses: The use of contact lenses as a substitute for spectacles is of secondary importance to the practicing physician. Knowledge of the medical importance of contact lenses in the care and treatment of various ocular and corneal diseases is growing daily. Much of this gain is the result of perfection of a special molded scleral contact lens by Ridley. This lens may be used for severe keratoconus, recurrent corneal erosion, symblepharon and scarring from chemical burn, Stevens-Johnson's disease, et cetera. Corneal lenses may be fitted over the aphakic eye, or the post corneal transplant astigmatism lenses may be utilized to cover iris deficiencies for increased visual efficiency or even to improve the cosmetic appearance of a quiescent but disfigured eye; even a microphthalmic eye may be covered. A contact shell may be used over an eviscerated globe with impunity.

Recently, a bill (House Bill No. 574) was passed by the state legislature which in essence allows licensed optometrists to practice fitting contact lenses, even with the knowledge of that which has been discussed heretofore. The bill passed in spite of objections raised by responsible members of the ophthalmologic specialty group of this state (including the chairmen of the respective departments of ophthalmology of both medical schools in the state). The bill passed practically without objection in either house or senate. The primary (and successful) argument of the lay group involved pertained to their longstanding utilization of contact lenses and advancements in the field. All this in spite of the arguments noted above. The basic problem as to who is responsible for the medical problems involved is of course unanswered.

How can the safety of the public be properly maintained and real knowledge gained in the medical use of contact lenses?

At Wayne State University College of Medicine a separate division of Ophthalmic Prosthetics has been set up under the Department of Ophthalmology. The purposes of this unit is as follows:

1. Proper training of resident personnel in the utilization of various ophthalmic prosthetics. A separate clinic is set up for this purpose, and shall include medical supervision in the fitting and wearing of contact lenses.
2. Statistical evaluation of various characteristics noted to be of value or hazard in various lens types and structures. This is to be accomplished by adequate data maintenance and processing.
3. Cooperation with various other university groups in the development of new materials, products, and methods.
4. Utilization of proper nomenclature and evaluation in the determination of proper qualities for contact lenses.
5. Basic research into the metabolism of the globe when prosthetics are utilized.
6. Dissemination of knowledge to postgraduates interested in the utilization of various ophthalmic prosthetics.

In the final analysis, the proper usage of prosthetic devices pertaining to the globe would appear to be a prerogative of the medical practitioner. Whether the medical profession can maintain this prerogative is a function of understanding, interest, and progress.

Medical Indications and Contraindications For Contact Lenses

Certain individuals may adapt themselves well to the corneal contact lens while others may require the full scleral or molded lens as popularized and perfected by Ridley.

Before attempting any actual fitting of contact lenses, one should have a pretty good idea of the patient's capabilities, structurally, physically, and psychically.

Indications.—

1. The primary requirement and indication for contact lens wearing is *desire*. The patient should not be "sold" contact lenses. The possible advantages and disabilities incurred in the wearing of lenses should be explained fully before the patient enters into the actual trial fitting. Many patients will be seen who desire only to get rid of their glasses. If the glasses are adequately fitted and the patient is having no difficulty with them, he (or she) should be carefully questioned as to his real need or demand for the lenses. There is little if any value to carrying out the demands in time and effort for proper contact lens

fitting to have the patient put them in a drawer and forget about them.

2. *Cosmosis:* Many patients will come to the ophthalmologist for contact lenses for cosmetic reasons alone. Actually most of such patients are probably seen by an optometrist because the patient is aware of no true visual difficulty. These patients are not the best contact lens wearers and again careful interrogation is necessary to determine the true need or desire for the lenses. The patient who feels a real cosmetic need for lenses will wear them successfully.

3. *High refractive error:* As long as the individual has no real binocular imbalance and has a notably good fusion range, contact lenses can be considered in the myope, astigmat, and the hypermetrope. The moderately high myope (> -2.50) will be extremely gratified in the wearing of lenses for they will not only have a bigger visual field but will be able to see more efficiently than with the use of spectacles. This is also true of an individual with moderate to high astigmatism and will be considered further in the evaluation of an individual having keratoconus. The hypermetrope may also be comfortable with contact lenses, but this group often has a related muscle imbalance and great care must be made to properly interpret the binocular status of the individual before fitting. In the group of refractive errors who are benefited by contact lenses one must include anisometropia, for an individual with an anisometropia will be truly benefited with properly fitting contact lenses.

4. *Occupational:* Certain individuals will find the wearing of spectacles unsuitable to their particular occupation. Telephone linemen, models, receptionists, salespeople, athletes and others who are in constant contact with the public or in those occupations where spectacles might be considered a hazard such as athletics, find true benefit in the wearing of contact lenses.

5. *Keratoconus:* Actually keratoconus should be considered under high refractive errors but it must be placed in a separate grouping because this is one which must be carefully considered from every point of view before actual fitting is considered. Keratoconus may be a progressive disease in young people. Under such circumstances the wearing of a contact lens must be controlled carefully by the physician. Difficulty in maintaining a proper fit may be an indication of change in corneal curvature. In a low grade of keratoconus a corneal lens might be worn, but when the keratoconus reaches a stage of central corneal thinning with scarring it may be necessary to utilize the molded Ridley type lens. Any case of keratoconus requires careful medical evaluation, including a complete allergic workup.

6. *Aphakia:* Both binocular and monocular aphakes handle contact lenses with relative ease and visual benefit. Their visual field is not only larger, but they would appear to maintain binocularity and have reasonable comfort. The lenses can be utilized through the complete working day.

7. *Corneal transplants:* It is not uncommon to find an individual who has a successful corneal transplant but who is unable to attain normal visual function because of severe refractive error following surgery. These individuals are able to wear contact lenses with comfort and visual improvement.

8. *Corneal scarring:* Small central corneal scars, inactive herpetic lesions as caused by trauma, inactive herpes may be benefited by a corneal lens. In some cases the lens may require a filter to properly reduce diffraction from the area of corneal scar. In many cases, however, contact lenses can be worn with improvement of vision. The corneal scarring of interstitial keratitis is occasionally benefited by contact lenses.

9. *Chemical burns:* It has been our experience that an occasional individual with severe chemical burns or recurrent corneal erosion from an old chemical burn can wear a scleral type molded lens with impunity and improvement in vision.

10. *Pupillary abnormalities:* The individual with an iridodialysis or visually debilitating iris lesion may wear a contact lens which has been colored to match the iris shade and get return of normal visual function.

11. *Nystagmus:* Some patients with nystagmus can wear contact lenses with great improvement in vision.

Contraindications.—

1. *Previously poorly fitted contact lenses:* The individual who comes under your care who has had or is wearing poorly fitting contact lenses may have entered into an abnormal corneal metabolic condition.

There may be recurrent corneal erosion, hypoanesthesia or anesthesia of the cornea. Real structural changes may evolve which persist even after the lenses are removed. These individuals may not be able to wear even properly fitted lenses thereafter.

2. *Muscle Imbalance:* Any muscle imbalance whether it be vertical or horizontal (meaning exophoria or esophoria) should be considered a poor risk for contact lenses and the patient should be carefully instructed as to the poor prognosis and potential wearability. A patient with reduced extra-ocular movement in any direction is not a good candidate for contact lenses.

3. *Photophobia:* The individual who has photophobia due to diminished iris coloration or partial albinism may be able to wear contact lenses. However, the individual who has unexplained photophobia and has a chronic blepharospasm is a bad candidate for contacts.

4. The individual with *ocular allergy* is a bad contact lens patient and should be deferred if possible.

5. The individual with *chronic inflammation of the lid* whether it be from a chronic staph infection or seborrhea not controlled should not be considered for contact lens wearing.

6. The individual with *chronic recurrent inflammation of the iris* or anterior segment should not be considered for contact lens wearing.

7. The individual with *chronic tearing or with keratitis sicca* should not be considered for contact lens wearing.

8. The individual with *chronic or recurrent erosion of the cornea* is a poor contact lens candidate unless the reason for the recurrent erosion can be brought under control.

9. An individual with *chronic glaucoma* is not a good candidate for contact lenses. As a matter of fact, some of the symptoms of chronic glaucoma can be obtained by individuals wearing improperly fitted contact lenses. For instance, a too tight lens may cause corneal edema with halo vision and light sensitivity.

10. *Endothelial dystrophy.*

11. A patient with *exophthalmos or lid retraction* probably is not a candidate for contact lenses; however, in some cases the Ridley type lens might be indicated if real control of the corneal surface can not be attained. For this reason some patients with old Stevens-Johnson's disease might wear a Ridley type contact lens, also those with trichosis due to scarring of the lids. The most important point, of course, is the proper evaluation of the patient from the point of view of structure, desire, mental attitude and type of lens.

1553 Woodward Avenue

Recommendations Re Mental Health

A shortened medical curriculum and more medical schools have been recommended by the president of the American Psychiatric Association in attacking the nation's great mental health problem.

"The manpower situation in psychiatry and all related disciplines dealing with mental illness is woefully inadequate," said Dr. Walter E. Barton. "We are not even reproducing our annual manpower losses in this field."

In his specific recommendations, Doctor Barton advocated that the medical training program be shortened and condensed from its present eight years to six years.

He declared that the nation needs at least twenty more medical schools in the very near future to help erase the increasingly critical shortage of physicians. Doctor Barton recommended liberalizing of the examinations and restrictions now placed against foreign-trained doctors which prevent them from practicing medicine and psychiatry in the United States.

He advised greater use of "part-time physicians," psychiatrists who have left mental hospitals for private practice but who still can be retained for part-time work in the mental wards.

The Surgery of Deafness

III. Tympanoplasty

Brian F. McCabe, M.D.

Ann Arbor, Michigan

THE AIM of the ear surgeon in the treatment of suppurative ear disease has been for many decades chiefly the elimination of infection from an involved temporal bone. Another aspect of mastoid surgery has now assumed an importance such that it is today an integral part of almost each operation done for chronic suppurative otitis media and mastoiditis. This new part of the operation is termed tympanoplasty. In it the salvageable remnants of the conductive mechanism of the ear are reconstituted so as to restore hearing.

The idea that otologists still perform mastoidectomies often puzzles the average physician, who assumed long ago that the era of antibiotics had sounded the death knell of suppurative mastoid disease, and with it, otolaryngology. Nothing could be farther from the truth. Antibiotics and antimicrobials forced the microbe kingdom to loosen its grip on the vertebrate-kingdom in allaying the early ravages of many acute infections; the former answered this challenge by clamping a new hold on the latter in the form of insidious chronic infections. This is demonstrated graphically by comparing the decline in the number of mastoidectomies done for acute infection over the past two decades with the rise in the number of those done for chronic mastoiditis. Whereas operations for acute disease have become uncommon, operations for chronic disease have become so frequent in incidence that they may soon equal in number the former.

That this should be so is only partly the fault of the antibiotics; it is also partly our fault. The majority of patients operated upon for chronic mastoiditis in the past five years were raised in the antibiotic era. It is self-evident that chronic mastoiditis can only have its origin in an unresolved acute otitis media. The increase in chronic mastoiditis, then, can only mean that there is an increase in the number of unresolved acute middle ear infections, undoubtedly because of injudicious use of antibiotics, inadequate followup, and the lamentable abandonment of the myringotomy knife by practitioners of medicine. Merely the cessation of pain or otorrhea does not herald the conquest of the infection. Treatment must continue until the tympanic membrane is normal and the middle ear air-containing or the upswinging curve of chronic mastoiditis will never peak.

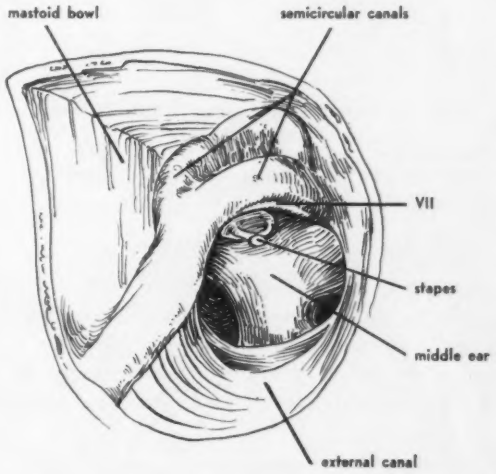

Fig. 1. The radical mastoidectomy. In it, the external canal becomes joined with the sculptured mastoid cavity. The middle ear is removed in all but its mesial wall and the common chamber becomes lined with skin.

The operation done for acute mastoiditis is essentially the drainage of a mastoid abscess, with sequestrectomy of necrotic mastoid cell walls, postauricular drainage, and (at least prior to antibiotic therapy) healing by secondary intention. It is done for acute osteomyelitis when the disease does not respond to antibiotics. Mastoid surgery for chronic osteomyelitis is however, an entirely different story. The chronic process does not respond to antibiotics and the treatment is always surgical. The surgery of chronic osteomyelitis is similar to the surgery of neoplasia, in that every minute remnant of the disease

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process must be eliminated to guarantee against recurrence. The process further is usually complicated by the presence of cholesteatoma, which also recurs unless scrupulously excised. This double operative burden carried out within the narrow confines of a

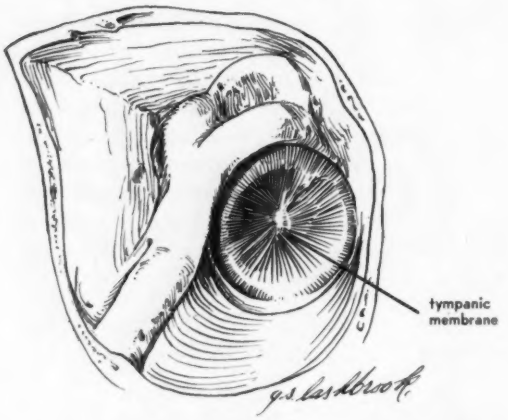

Fig. 2. The modified radical mastoidectomy. The middle ear is preserved, separate from the common chamber of external canal and mastoid bowl. The success of this operation in preserving hearing stimulated the development of tympanoplasty.

host of vital structures—cerebellum, facial nerve, cerebrum, sigmoid sinus, vestibular labyrinth, jugular bulb, and cochlea, make of the radical mastoidectomy not the simple curettage of a half-ounce of bone but a virtual sculpturing of an angular chamber leaving in bold relief thin bony plates over the brain and inner ear.

The radical mastoid operation is in essence a conversion of the mastoid and middle ear cavities into a common chamber with the external auditory canal, with the sacrifice of any remnants of tympanic membrane or ossicles which resisted the disease process. This cavity becomes lined with skin growing in from the canal opening. It seemed unnecessary to early ear surgeons to sacrifice the middle ear, and hence hearing, when this chamber was largely undiseased, and so a great step was taken in the evolution of mastoidectomy: the preservation of the middle ear and conversion of the mastoid cavity and external canal to one chamber. This election possible in some cases came to be known as a modified radical mastoidectomy.

The next step in evolution came about through the efforts of pioneering ear surgeons such as Wullstein and Zollner to preserve hearing even in cases where the middle ear was greatly impaired by disease.

Tympanoplasty has as its objectives the elimination of irreversibly diseased tissue, and the preservation of normal and reversibly diseased tissue important in the conduction of sound pressure to the inner ear. It is obviously an election not possible in every case of chronic mastoiditis, for example it is pointless to take great pains in preserving the middle ear when a coexisting perceptive deafness makes serviceable hearing unattainable. This is probably an absolute contraindication to tympanoplasty; there are also relative contraindications such as cicatricial stenosis of the

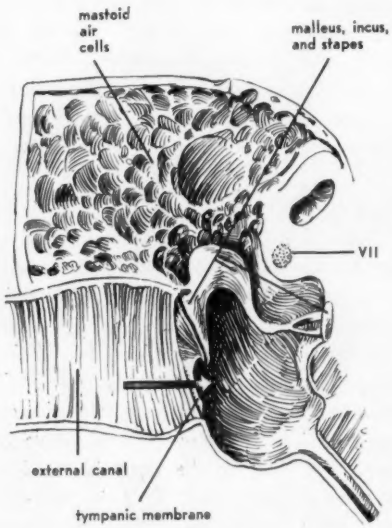

Fig. 3. *Tympanoplasty Type I*: this is basically a myringoplasty, or closure of an existing perforation. Arrow indicates perforation.

eustachian tube, neoplasm, and cholesteatosis of the middle ear. In these cases it may be prudent or necessary to perform a radical mastoidectomy.

Thus it is inadvisable to do a tympanoplasty each time a mastoidectomy is done. As long as chronic osteitis and osteomyelitis of the temporal bone remain surgical diseases, the classical radical mastoidectomy will never perish.

In those cases however where salvage of the middle ear is feasible, tympanoplasty today offers a greater chance than ever before of not only eliminating the life-threatening complications of mastoiditis but of restoring the ear to usefulness.

The variations of technique in tympanoplasty are determined by how much of the middle ear is left after the excisive part of the operation. These varia-

tions are not completely standardized and perhaps never should be, but a number of variations have been developed by Wullstein, which have gained such wide acceptance that no discussion of tympanoplasty is complete without a résumé of them.

Type I. This is essentially a myringoplasty or restoration of the continuity of the tympanic membrane. A mastoidectomy is not done, but certain measures are usually carried out to ensure the safety of the procedure. In event of a marginal perforation for example, it is necessary to exclude the possibility of

Fig. 4. *Tympanoplasty Type II:* the mastoid bowl and external canal are converted to one chamber, but the entire ossicular chain and middle ear are retained under a skin flap.

cholesteatoma in the mastoid antrum or tympanic attic. It may only be carried out when the middle ear is absolutely free of suppuration or mucorrhea. Wullstein and other Europeans advocate the use of a full-thickness post-auricular free skin graft to close the perforation, but American otologists now prefer vein wall tissue, canal wall pedicle or free grafts, or a combination of these.

Type II. A mastoidectomy is performed and this cavity is made confluent with the external canal but the ossicular chain is left intact. A free full thickness graft is used to cover any exposed portion of the ossicular chain and close the existing perforation. It is indicated in relatively few cases and should not be performed where cholesteatoma involves the tympanic attic. In this event the chances of incomplete cholesteatome removal, e.g., from the mesial surface of the body of the incus, are high.

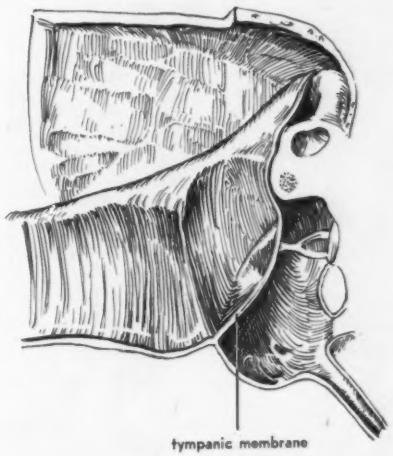

Fig. 5. *Tympanoplasty Type III:* when the incus is diseased and requires removal, the tympanic membrane may be titled inward to rest against the stapes.

Type III. This variety of tympanoplasty is identical to the modified radical mastoidectomy when the viable tympanomeatal flap is used. The tympanic membrane is tilted inward and brought in contact with the stapes. The incus and malleus are removed, or the malleus handle alone may be left behind. Where the perforation is wide, a free graft may be used as described by Wullstein, but a sliding bipedicle or monopedicle has many advantages over a free graft (cf. The Surgery of Deafness I, in this series). Canal flaps, free canal skin, and vein wall are proving so far superior to extra-auricular skin that few ear surgeons now advocate the use of the latter.

In all the above types, normal hearing may be attainable when the hearing loss is of middle ear origin. In each type, reconstructive measures are adequate to produce sound pressure levels at the stapedial footplate similar to those in the normal ear.

Type IV. Where the stapedial crura are absent through disease, no remaining part of the ossicular chain can be used in the reconstruction. In this type, the footplate of the stapes is open to the large common chamber and a lower-half middle ear is created joining the round window and eustachian tube orifice. This

inferior air chamber ("cavum minor") provides sound insulation to the round window so that ararefaction wave arrives at the round window membrane at the time a compression wave strikes the stapedial footplate. This favors basilar membrane deflection in the inner ear, and hence, hearing. But without the favorable areal ration between tympanic membrane and stapedial footplate as in types I-III, hearing suffers, and the best level that can be expected in the type IV tympanoplasty is 26 db. Although not normal, this hearing is serviceable and is better than the 45 db to 60 db the radical mastoidectomy usually affords.

Fig. 6. *Tympanoplasty Type IV:* with the entire ossicular chain destroyed, serviceable hearing may be achieved by providing sound protection to the round window.

Wullstein also describes a fifth type which is seldom performed today. It is designed to meet the condition of a fixed footplate, and is a combination of a type IV tympanoplasty and the classical fenestration operation. Unless the middle ear and mastoid are completely free of suppuration, it is performed in two stages. With the advent of newer techniques, it is, like the fenestration operation, passing into relative obscurity.

It is readily apparent there is not much which is startlingly new in the four or five types of tympanoplasty. Type I has been known for generations as a myringoplasty, and type III as a modified radical mastoidectomy. Types II and IV represent newer concepts of middle ear reconstruction but type II is technically no easier than modified radical mastoidectomy while producing the same expected hearing result, and type IV is most remarkable only in its inability to produce a satisfactorily high rate of serviceable hearing in spite of its soundess physiologically. However, there is no question of the fact that Wullstein has done otolaryngology a great service in his logical organization of this subject material and his reassessment of the possibilities of conservatisim in tympanic surgery.

As alluded to, the type IV tympanoplasty produces the most disappointing results in restoration of hearing. In our series, only 25 per cent of those patients in whom this procedure was the only election surpassed the 30 db line on their last audiogram. This experience does not differ greatly from other reported series of type IV tympanoplasties in this country. This is not unreasonable in this operation as designed if one considers the numerous possible causes for failure. It must be realized that the theoretical highest attainable hearing level in this operation is 26 db. If the suppurative process in the middle ear and mastoid has been extensive enough to produce necrosis of the stapedial crura, extensive albeit reversible inflammation of the tympanic mucosa takes place by contiguity. As this suppurative inflammation subsides, subepithelial fibrosis can be expected to occur as part of the healing process. This fibrosis maturing to cicatrization can involve the key points in the middle ear as well as elsewhere, and when it occurs

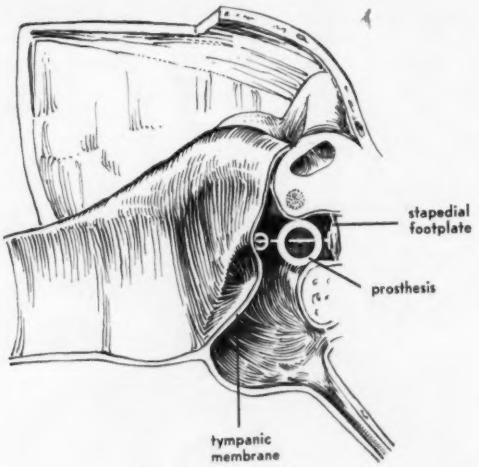

Fig. 7. A *Type IV Tympanoplasty* may be converted to a *Type III* by the employment of a polyethylene-stainless steel prosthesis. The foot of the steel columella rests against the footplate of the stapes. It is stabilized by a length of polyethylene 190 tubing, resting securely in the oval window niche. An end-button of smaller polyethylene prevents its piercing through the tympanic membrane.

in normally highly supple structures such as the round window membrane or stapediovestibular ligament, some depreciation of response to sound pressure can be expected. If this attenuation amounts to only 10 db, the hoped-for hearing level of 30 db cannot be reached.

The most logical solution to this dilemma is to provide in the operative technique a mechanism whereby sound pressure at the stapedial footplate can be increased. In the type IV tympanoplasty, the tympanic membrane is utilized to provide only sound protection to the round window. By recruiting it to do also its prior job of gathering sound pressure for

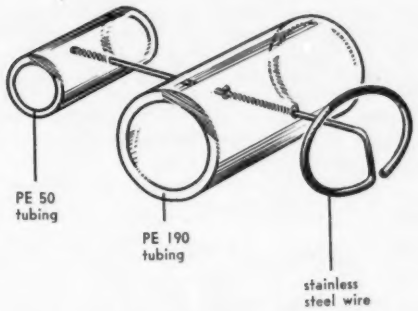

Fig. 8. The composite prosthesis. The steel columella slides freely through the PE 190 stabilizer.

delivery to the footplate, this objective would be reached. By restoring the areal ratio of tympanic membrane to footplate, even normal hearing would be attainable.

This can be accomplished by restoring the full height of the mesotympanum and connecting the tympanic membrane to the footplate across the air chamber. The direct connection by polyethylene between the footplate and the malleus handle described in the second article of this series is not feasible here because the looseness of the tympanic membrane renders the prosthesis unstable. A successful prosthesis must have an inherent stability. The cross-bar prosthesis described by Hayden was tried without success, as cicatrization slowly pulled it out of position. Many attempts at development of a stable prosthesis have resulted in a polyethylene-steel composite, much resembling a cross of Lorraine in configuration. The stem is No. 34 steel wire, with a loop at one end resting on the footplate. The stem slides freely through a short piece of PE 190 pierced transversely, which acts as a stabilizer. This piece of polyethylene sits snugly between the intratympanic course of the facial nerve and the promontory, in the oval window niche. The outer end of the stem is capped with a shorter piece of PE 60, which prevents its piercing the tympanic membrane or graft. A free graft is never used for this purpose, as it tolerates point-

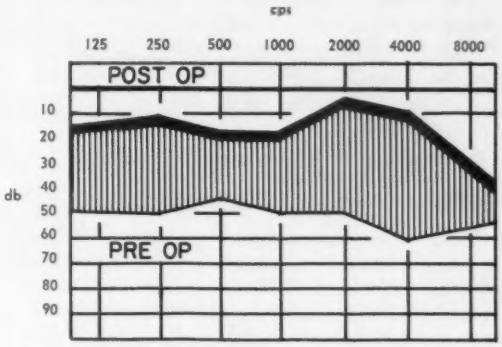

Fig. 9. Typical audiometric result showing the gain in hearing (shaded area).

pressure poorly. A perforation existing in this area is closed by sliding the tympanomeatal flap forward. Six cases which would have been type IV tympanoplasties by prior standards were converted to type III tympanoplasties by this method with uniformly satisfactory results.

Summary

After an initial fall in incidence occasioned by the advent of antibiotics, mastoidectomy is now increasing in incidence. This rise is by virtue of the increase in chronic mastoiditis. Most mastoidectomies today involve also some attempt at preserving or restoring the hearing mechanism. The discipline concerned with the organization of audiosurgical restorative techniques is termed tympanoplasty. Various types of tympanoplasties are feasible depending upon what is left after the excisive portion of the operation. Of these, type IV is the least successful. A higher degree of hearing is attainable with the use of a composite polyethelene-steel prosthesis and total restoration of the middle ear.

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Findings, Recommendations and Orders of the Insurance Commissioner, State of Michigan

On January 10, 1961, the Michigan Medical Service (Blue Shield) and the Michigan Hospital Service (Blue Cross) submitted to the Michigan Department of Insurance filings for which approval was requested.

The Blue Shield filing included:

1. A rate increase of 13.5 per cent projected for a two-year period, effective April 1, 1961.
2. The following certificate changes:
   (a) Substitution of days for months in respect to benefit waiting periods, benefit renewal periods, etc. (9 months would become 270 days; 3 months would become 90 days);
   (b) Reduction of the renewal period for tuberculosis, nervous and mental conditions, from 6 months to 90 days in all certificates;
   (c) A guarantee of a minimum of 30 days of in-hospital medical care for the treatment of an accidental injury when a member has less than 30 days of such care available at the time of such injury;
   (d) To allow obstetric and medical benefits for individual subscribers, as well as the two-person and family certificates with respect to group conversion contracts only.

The Blue Cross filing included:

1. A rate increase of 22.04 per cent projected for a two-year period, effective April 1, 1961.
2. The following certificate changes:
   (a) The 30 days hospital benefit period for the treatment of tuberculosis, nervous or mental conditions is to be incorporated into the present maximum benefit period of the certificates. As a result, the renewal proviso will be shortened from a 6-month waiting period without hospitalization for any condition to a 90 day period.
   (b) The maximum benefit period (120 days in the Comprehensive and the $50.00 Deductible Certificates; 30 days in the Economy and Non-Group Certificates) will be extended so as to provide at least 30 days of hospital care for the member admitted for initial treatment of traumatic bodily injuries immediately following an accident causing such injuries. For example, a Comprehensive member having exhausted 110 of the 120 days in a benefit period will be entitled to 20 days beyond the benefit period or a total of 140 days in that benefit period.
   (c) An additional new benefit will provide hospital care, on both an in-patient and out-patient basis, for dental treatment, if the service is for oral surgery, extraction of impacted teeth, multiple extractions under general anaesthesia or treatment necessary to safeguard the life or health of the member from the effect of dentistry because of a non-dental organic condition.
   (d) Group Conversion (Direct Payment) benefits will be modified to correspond with those furnished under the group certificates.
      (1) Full maternity benefits instead of a $14.00 per day room allowance.
      (2) Maternity benefits allowed on single contracts.
      (3) 120 days allowed instead of 30 days.
   (e) Maternity benefits will be provided on all certificates after 270 days of membership instead of after 9 months of membership under contracts that include maternity care as a benefit.
   (f) All time intervals related to benefit provisions are to be expressed in days instead of in months.
   (g) When a member is hospitalized in a non-participating hospital, the Service Association will provide $15.00 per day as an allowance rather than the present $14.00. The room allowance under the Economy and the $14.00 Daily Room Benefit Non-Group Care Certificates will be raised to $15.00.
   (h) The deductible payment to the hospital under the $50.00 Deductible Certificates will not be required for children. Such members will receive full contract services without the deductible charge until the end of the calendar year in which the age of 19 years is attained.
   (i) Several non-substantive changes in contract language are made.

Public hearings were held on these filings on February 7, 1961, in Detroit; February 15, 1961, in Grand Rapids; and February 16, 1961, in Lansing. Prior to the formal submission of these filings, examiners and other personnel of the Department of Insurance began a special study and review of the financial status, organizational structure, practices and procedures of both Michigan Medical Service and Michigan Hospital Service. In addition, consultations were held with Professor Walter J. McNerney and his staff at the University of Michigan, who have been engaged in a special study for the Governor's Commission on Pre-Paid Hospital and Medical Care Plans. Various members of the Department of Insurance also analyzed the great volume of mail directed to the Department and conferred with individual citizens (both professional and laymen) who indicated their desire to express personally their views with respect to any aspect of the filings submitted. Every conceivable effort was made to ascertain the pertinent facts on which a decision should be based.

General Discussion

Sitting through the public hearings on these applications for a rate increase has made me most mindful of the impact our decision will have on nearly 3½ million citizens of Michigan and the Blue Cross-Blue Shield programs. The importance of our decision is heightened by the sober reflection that the responsibility of this decision is, by law, vested in one man alone, the Commissioner of Insurance. The effect of his decision on the public's pocketbook can be just as

great as the enactment of a major tax measure by the Legislature. It is for this reason that I have carefully weighed every conceivable factor having a bearing on the question presented to me. In all the din that developed since the initial announcement that Blue Cross-Blue Shield would seek approval of a rate increase, I have recognized that my paramount responsibility was to arrive at a decision that would reflect the public interest, rather than the interest of any specific group who happen to have an identification with either program. Our orders and recommendations have been based on what the facts have disclosed to be necessary. There are no miracle ingredients or nostrums that would provide a basis for a determination acceptable to all concerned and at the same time resolve the problems confronting both organizations.

Our study of these two voluntary prepaid hospital and medical care plans indicates that they have, in the main, met popular expectations with respect to the purpose for which they were established. The good things they have accomplished over the years are conspicuous. Given their shortcomings, their importance to the health and well-being of our citizenry is beyond dispute. Our study also revealed that there is no persuasive evidence that any substantial savings can be accomplished in reducing the administrative costs of either plan. Such costs appear to be reasonable in relation to the size of the total operation.

Because of the recent history of rate increases, however, there is widespread consumer objection to the price that both plans charge for their services. This objection threatens the continued existence of both plans.

How to meet the objection of price is a hard question, but an urgent one. Our examination discloses that the financial status of Blue Shield is precarious, and it is only a question of time before the well runs dry. It is clear that our choice of alternatives for the solution of the financial problem is limited, increase rates or drastically reduce subscriber benefits. The financial picture for Blue Cross is only slightly less critical.

The public question as to why this should be cannot be answered by an explanation of spiraling medical costs, increased utilization and possible misuse alone. Indeed, both plans seem to have engaged in a calculated program of liberalizing benefits when it was apparent that they were headed for financial difficulty. The claim that the public wanted or demanded extension of coverage ignores the fact that private interests can be advanced under the cloak of giving the public what it supposedly wants. There have been, and still are, protagonists of both plans who fail to recognize that there are practical limitations to what people can afford to purchase, or that they are willing to buy.

Beyond the financial question, both plans are experiencing other perplexities and troubles. It is obvious that the maintenance of membership is a serious problem which must be faced by both organizations. Blue Shield has to cope with subscriber dissatisfaction occasioned by fees charged by non-participating doctors beyond those fixed in the Blue Shield schedule. There is also dissatisfaction among participating doctors as to Blue Shield's fee schedule. Some charge this schedule is weighted in favor of certain specialists to the disadvantage of general practitioners, internists, etc. This situation could well lead to an increase in the number of non-participating doctors who have no ceiling on the fee they can charge in addition to what they collect from Blue Shield.

Blue Cross is faced with comparative problems with respect to their hospital payment formula to participating hospitals. That this formula is vulnerable to criticism needs no further emphasis than that supplied by Blue Cross in their publication "The Status and Operation of Michigan Hospital Service," dated January, 1961. On page 71 of that report it is noted that critics of the formula charge: "The payment formula includes no positive incentive toward efficiency in operation, nor does it include a positive penalty for inefficiency in operation, or unwarranted increases in hospital operating cost." Non-participating hospitals, ineligible to become participating hospitals, are also most critical over the payment allowance which they receive. We found many subscribers were unaware that they are not eligible for full benefits under their Blue Cross contracts unless they are confined in participating hospitals.

Internally, both corporations have established control measures to police abuse and misuse of their respective services. Such control measures are good to the extent they are utilized. However, more successful efforts are dependent upon the cooperation of the public, the doctors and hospital administrators. While we are unable to document the extent of abuse and misuse, we are of the opinion that there is a tendency by many professional people to minimize the prevalence of such practices. The vast number of complaints on this score are not susceptible to evaluation by our staff. However, numerous communications and conversations leave no doubt that a great number of our citizens have become cynical about the propriety and equity of some medical and hospital charges.

Quite conceivably, the source of much of the public's misunderstanding and complaint stems from the schedule of payments to doctors in non-surgical confinement cases. They receive, depending on the subscriber's contract, as high as $15.00 for the first day of confinement in the hospital; $6.00 per day from the second to the twentieth day; and $4.80 per day from the twenty-first to the one-hundred and

twentieth day. These fees are automatic and do not depend on the doctor providing any further service, other than being the admitting physician.

Our review and study establishes the impression that administrative personnel in both organizations are more responsive to the views and opinions of doctors and hospital administrators than those of the public. On more than one occasion we have noted examples of administrative timidity when confronted with opposition of segments of the medical profession over administrative decisions. This timidity becomes particularly obvious when propositions are advanced to secure amendments to their enabling acts. They have spent too much time convincing themselves that such action would not be in the best interests of their programs. Certainly, a review of the franchise under which they are operating with doubt and discomfort would be in order and in the public interest.

At the present time, Blue Cross handles the auditing of some member hospitals in a cursory fashion. Thorough audits are of vast importance in determining benefit payments to the hospitals. It would appear that Blue Cross is loathe to throw its weight around to require sound accounting procedures such as set forth by the American Hospital Association.

In this general discussion, we have attempted to highlight the more important findings of our various efforts. More specific detail will be found in the Survey and Review written by staff personnel. I fully expect that more complete findings will also be supplied by Professor McNerney's inquiry and that these will be even more thoroughly documented than time permitted us to undertake.

Our discussion is not for the purpose of finding fault, but rather to point up the fact that both of these corporations are looked upon by more and more people as quasi public utilities. It is obvious that this must be recognized and both organizations charged with a greater degree of public accountability. This becomes tremendously important if prepaid voluntary health programs are to survive the challenges that confront them. Challenges such as the greater percentage of elder citizens, unemployment of so many of our workers and the financial impact that the cost of these programs have on employers, who in many instances pay all or part of the cost of the coverage.

The Michigan Blue Shield and Blue Cross programs rank among the best in the United States in terms of benefits provided and administrative costs of the plans. The service they have rendered has been invaluable in providing the citizens of Michigan necessary health care. The following recommendations and orders are presented to assist management in continuing to provide such service and at the same time meet their financial requirements.

Recommendations

The distinctive feature between the Blue Shield-Blue Cross programs from other forms of health insurance is their intimate relationship with the medical profession and the health services industry.

We urge that the various professional organizations representing such groups extend more extensive assistance in resolving the pressing problems that have occasioned public criticism of Blue Shield-Blue Cross.

It is in the public interest that as many doctors as possible participate in their own plan.

We recommend that the Michigan State Medical Society and its constituent groups initiate such action as necessary to accomplish this end.

We have noted with interest that a great number of committees have been established within the Blue Shield-Blue Cross organizations.

It is recommended that the scope of such committees' assignments and the extent of their activities be reviewed to determine whether they are meeting their original purpose in the most efficient and effective fashion.

Our mail and public hearings indicated considerable public interest that deductible provisions be included in both Blue Shield and Blue Cross contracts. Without commenting on the merits of existing deductible provisions already provided for and contemplated, it is obvious that the public is not aware of their availability.

It is recommended that steps be taken to acquaint subscribers of such deductible provisions so they may exercise freedom of choice.

Ambiguous language in both Blue Shield and Blue Cross contracts causes considerable confusion in the minds of subscribers as to the benefits to which they are entitled. This has also opened the door to administrative interpretations of contract benefits which has been a source of irritation to some claimants.

It is recommended that thought be given to ways and means of modernizing such contract language to assist the public in understanding what they are purchasing.

The following recommendations are advanced for the consideration of the Michigan State Legislature:

1. *Public Acts 108 and 109, Public Acts of 1939, be amended to require that a majority of the members of the governing bodies of both corporations be public members.*

2. *Public Act 108 be amended so as to make it possible for doctors of osteopathy to become participating doctors.*

3. *Public Act 108 and Public Act 109 be amended so as to require the filing of lists of participating doctors and participating hospitals with each county clerk. Such lists to be limited to participating doctors*

and participating hospitals within each county. Similar lists should also be required to be kept on file in each branch office of Blue Shield and Blue Cross located in Michigan. These lists to be open and available for public inspection.

4. That consideration be given to the feasibility of placing the authority in some state agency for the approval of hospital rates.

5. That provision be made within the budget of the Department of Insurance for two auditors to be permanently assigned to Blue Shield and Blue Cross.

Orders

With respect to the Blue Shield filing:

1. Michigan Medical Service is hereby granted a rate increase in the amount of 10 per cent, effective June 1, 1961, and conditioned upon the Michigan Medical Service having, prior thereto, submitted to the Commissioner of Insurance of the State of Michigan a plan acceptable to the Commissioner whereby the contingency reserve, over and above all liabilities, shall be maintained. This reserve shall consist of monthly accumulations equal to 3 per cent of each month's premium income, until such time as the reserve equals three months' premium income. No plan will be approved which contemplates an increase in subscribers' rates beyond that granted herein or a reduction in subscriber benefits heretofore and herein authorized by the Commissioner of Insurance.

2. The following certificate changes are approved:

(a) Substitution of days for months in respect to benefit periods.

(b) Modification of group conversion benefits to correspond with those furnished under the group certificate: (1) Maternity benefit allowance on single contracts.

3. All other certificate changes for which approval was requested are hereby disapproved.

This action is taken because of the failure of Michigan Medical Service to exhibit an adequate basis to substantiate their projected costs. Those extensions of benefits denied herein may be resubmitted if limited to those subscribers who are willing to pay an additional premium, such premium to be both reasonable and adequate for the benefits provided.

With respect to the Blue Cross filing:

1. Michigan Hospital Service is hereby granted a rate increase in the amount of 20 per cent, effective June 1, 1961. Michigan Hospital Service is directed to set aside 3 per cent of earned premium income until the assigned reserve equals three months' premium income.

Our approval of a 20 per cent rate increase for Michigan Hospital Service reflects a 2.04 per cent reduction from their original request. The reduction in income that this cut will occasion will be minimized by our denial of certain extensions of benefits requested in Blue Cross' application of January 10, 1961.

It is also anticipated that increased emphasis on unnecessary utilization and stricter accounting requirements for participating hospitals should also result in further savings.

2. The following certificate changes are approved:

(a) Modification of group conversion benefits to correspond with those furnished under the group certificates. (1) Full maternity benefits instead of a $14.00 per day room allowance. (2) Maternity benefits allowed on single contracts. (3) 120 days allowed instead of 30 days.

(b) Maternity benefits to be provided on all certificates after 270 days of membership instead of after 9 months of membership under contracts that include maternity care as a benefit.

(c) All time intervals related to benefit provisions to be expressed in days instead of in months.

(d) Increase in allowance for non-participating hospitals from $14.00 per day to $15.00.

(e) Deductible provisions not to apply to children under the age of 19 years in the $50.00 deductible certificate.

(f) Certain non-substantive changes in contract language.

3. All other requested changes are hereby disapproved.

We have approved certain extension of benefits under the Blue Cross coverage because of their social desirability. The costs of such changes have been adequately documented and costs have been included in the requested rate increase. Specifically, these will correct certain inequities with respect to those individuals who find it necessary to switch from group plans to direct payment contracts. A large number of these people are unemployed workers and retirees. Relief has also been granted to non-participating hospitals in that equity would seem to call for such action. Those extensions of benefits denied herein may be resubmitted if limited to those subscribers who are willing to pay an additional premium, such premium to be both reasonable and adequate for the benefit provided.

Conclusion

Undoubtedly, our action in approving an increase in the cost of Blue Shield-Blue Cross coverage will be critically received by many of our citizens. The decision was not an easy one and it was made more difficult by a realization of its impact on elder citizens with limited incomes and the unemployed.

If there had been some alternative solution we would have advanced it. In the absence of any substitute program to meet the health needs of the 3½ million Blue Shield-Blue Cross subscribers, we are compelled to recognize our responsibility to maintain the solvency of both corporations so that they might meet their contractual obligations to their subscribers.

The necessary increase in rates is not unique to Michigan. In the past year such states as Maryland, New York, New Jersey, Ohio and Pennsylvania have found it necessary to grant increases; in most instances even larger than those we have granted.

We recognize that this is small consolation to those who must dig deeper to pay the increase and those who must contemplate dropping their coverage because of inability to afford it. Still, we would not be justified in depriving those who are willing and able to pay for such coverage the chance to procure it. An arbitrary or capricious denial of the requests would inevitably have had these consequences.

The public discussion of this question has had a healthy effect. It should cause all of us who are identified with the programs, no matter our role, to search for ways and means to improve both programs. We must do this, as well as stabilize the cost of such coverage, if these plans are not to be replaced with some other type of health care plan. The American people have always turned to other remedies when existing institutions failed or were not able to meet their responsibilities.

FRANK BLACKFORD, *Insurance Commissioner*
April 6, 1961.

Boston University Appoints Dean

Lamar Soutter, M.D., professor of surgery and acting dean since September, has been appointed dean of the Boston University School of Medicine. He has been associated with the University since 1952.

Drug Firms Aid Project HOPE

Fifty-two prescription drug manufacturers contributed in excess of $780,000 in products and cash to Project HOPE, according to Dr. William B. Walsh, president of the People-to-People Health Foundations, sponsor of the Project. Over $100,000 of the companies' contributions were in cash. Product values were computed according to manufacturers' wholesale prices.

"The support of the member companies of PMA has earned the unending gratitude of the people of Indonesia and Vietnam," Dr. Walsh said, "and it serves as an example of enlightened generosity to our own fellow citizens. This response has earned the deepest gratitude of all of us connected with Project HOPE."

HOTEL RESERVATIONS
MICHIGAN STATE MEDICAL SOCIETY

96th Annual Session

Grand Rapids, September 27-28-29, 1961

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to the Committee on Hotels for MSMS Convention, Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

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Committee on Hotels,
Michigan State Medical Society
c/o Jack Ament, Room Reservation Manager
Pantlind Hotel, Grand Rapids, Michigan

Please make hotel reservation(s) as indicated below:

_____ Single Room(s) _____persons

_____ Double Room(s) for _____persons

_____ Twin-Bedded Room(s) for _____persons

Arriving September _____hour_____A.M._____P.M.

Leaving _____hour_____A.M._____P.M.

Hotel of First Choice: _____

Second Choice: _____

Names and Addresses of all applicants including persons making reservations:

Name	*Address*	*City*	*State*

Date _____ Signature _____

Address _____ City _____

• **THE HOLDER OF A HOTEL RESERVATION** who fails to show up . . . and fails to cancel his reservation . . . causes gastric hyper-peristalsis, hypersecretion of the hydrochloric acid, and rubus of the gastric mucosa to the hotel manager.

When convention reservations fill a hotel to the capacity, a room not occupied is a loss in $$$ that cannot be reclaimed.

The MSMS Annual Session always means a capacity house in the Grand Rapids headquarters hotel.

Be kind to the hotel manager . . . be good to MSMS . . . be generous to your patients . . . be a friend to yourself—by showing up at the hotel of your choice in Grand Rapids, for the three days of the MSMS Annual Session.

Order your hotel accommodations today

Why Contact Lenses?

Why should the medical practitioner know about contact lenses? Why should the medical practitioner be concerned with ophthalmology's problems with contact lenses?

Why! Your patients are being fitted and are wearing them. If you are concerned with their physical health, then you must be concerned with the health of their most delicate sensory organ—the eye.

If your patients ask your professional advice about the advisability of wearing contact lenses, what is your answer? Your answer should be based on this additional information. *Why* does the individual want contact lenses? *Who* will do the fitting? *How* regularly and skillfully will the follow-up evaluation be done?

The "*Why*" should have a medical background and not be a whim precipitated by glamour advertising. Contact lenses improve vision and visual fields in large or irregular refractive errors, particularly the hyperopia of the post-cataract extraction patients. Contact lenses give vision to many patients whose occupations make wearing spectacles difficult or impractical. There is a group of patients with corneal disease or injury that can be helped with corneal contact or scleral molded lenses today. The success and practicality of these improvements in ophthalmology are presented for your general knowledge and information.

The "*Why*" dealing with purely cosmetic reasons as "My girl friend has them," or "My boy friend thinks I look terrible in glasses," may lead to wasted time, money and unhappiness without complete understanding. It is here that your responsibility as the family physician and our responsibility as the ophthalmologist is the making of an accurate, thoughtful decision. Plastic surgery has proved the psychological advantages of improved appearance; and now when vision is limited or restricted, contact lenses can give the same psychological advantages. But only that intangible sixth sense developed by years of medical training and experience will enable the physician to give the needed advice.

The "*Who*" is extremely important. Contact lenses are prosthetic devices and thus require medical observation and evaluation by an ophthalmologist before, during, and after fitting. The health of the eye must be checked by refraction, funduscopy, biomicroscopy, tonometry, perimetry, and motility testing before contact lens consideration. Then after the lenses are worn, this testing is equally important for protection of the eye.

Then the "*How*" follows. Will the patient's eyes be checked

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regularly even after apparent successful wearing has been accomplished? The early corneal trauma, degenerations and vascular changes can be diagnosed before permanent change only by careful three to four-month regular examinations. How regularly and skillfully a patient will be evaluated is of prime concern in sound advice to the prospective contact lens wearer.

Ophthalmology is working, studying and learning belatedly about this relatively new field in a scientific analytical fashion. Part of this study must be the education of the entire medical profession in a general understanding of contact lenses, their limitations, indications, and dangers.

—ROBERT J. CROSSEN, M.D.

Insurance Commissioner's Report

In this issue of THE JOURNAL, we are publishing in full the Insurance Commissioner's Report, findings and orders following the request of Blue Cross and Blue Shield for rate increases. Blue Shield, Michigan Medical Service, will accept under protest, and attempt to live with the restrictions. Blue Shield is thankful for the many complimentary remarks. Successful operation will require meticulous cooperation by both patients and doctors who render service as well as diligent administration. The State of Michigan cannot afford to lose this service.

Not Licked Yet

The American Medical Association Annual Conference held in New York City, June 25-30, 1961, was probably one of the most important ever held, not only for its scientific excellence, but from the standpoint of medical economics, the problems the profession must face, threats to its independent existence, and the future. Every member of the House of Delegates was in attendance (either the delegate or his alternate) probably for the first time in history. The councils, boards, committees, the executive officials, all had their reports prepared, most of them in a pre-convention volume. The Board of Trustees had an unusual number of supplemental reports. There were more than 115 resolutions presented from various sources, state medical societies, delegates, sections, et cetera—an unprecedented number. Most of these were in support of certain federal legislation, administrative problems, ethical and professional ideas including some economic questions. Some were in active opposition to King-Anderson type legislation.

Many of these reference committees had fifteen or twenty resolutions to study, and worked all night, hearing anyone who wished to testify and then working out the mimeographed reports. The most important had to do with legislation and public relations. This topic was also considered by the Conference of Presidents and Other Officers of State Medical Societies.

Conference of Presidents

The Conference was established originally by Dr. Andrew S. Brunk, former President of the Michigan State Medical Society, who called a special meeting of seventeen presidents to consider unsolved problems at the time, outside the purview of the American Medical Association. They were largely problems of procedure and methods growing out of the newly developed medical care for our people, and how to pay for it. Medical pioneers in Michigan, California, and in some other areas, evolved a method of prepayment for medical and hospital care. In operation, the plan was a success. Problems developed, but the people were being cared for. The first Conference of Presidents took up those questions and many others which came up during the years. This year, 1961, the prime question was federal legislation. Two congressmen were on the schedule and talked to the largest group ever assembled for this conference, which was completely and enthusiastically supported by the officials of the American Medical Association. Congressman Bourwald E. Hall, M.D., of Missouri, and Walter H. Judd, M.D., of Minnesota, cautioned about the political activities, bureaucratic encroachment and progressive extension of government control of the practice of medicine. Apparent bureaucratic disaffection with the Kerr-Mills Bill, which is now giving service to the aging, was cited. Bureaucratic approach, support and efforts to enact the King-Anderson type of legislation, would put medical care under social security and its special tax. The socializers are misinforming people, by obviously not including medical attention which has been promised. That type of legislation (King-Anderson) is totally insufficient.

House of Delegates

This introduction to the doctors, state and local officers, delegates and alternates, set a sober atmosphere for the House of Delegates. Numerous resolutions bearing on this same general topic gave the reference committee on legislation and public relations

a tremendous amount of work to do. They held many hours of hearings at which everyone was urged to testify and no one was denied. Then they spent most of two nights writing their report. We shall quote and comment upon one small section of that report which was adopted unanimously:

"Your reference committee strongly recommends that the House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

"The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party in implementing any system which we believe to be detrimental to the public welfare."

Most of this resolution was introduced on the floor by Louis H. Bauer, M.D., Past President of the American Medical Association, after a speech in which he invited attention to the fact that never had the medical profession been faced with such vital implications and threats as now—not even in the Wagner-Murray-Dingell Bills of twenty years ago.

What of the Future?

When he introduced the resolution just quoted, Dr. Bauer described the bureaucratic take-over of medicine and the refusal to use the Kerr-Mills Bill which is now caring for, or could if allowed, the aging in most of the states. The bureaucratic socializers claim that 12 million people are without care and must have it—therefore the King-Anderson Bill must be passed.

Where will the medical profession be? Physicians are specifically not included in this administration program. Very specifically, hospital care is provided after the patient pays the first $90; diagnostic care is included after the patient pays the next $20. Under the law, the only way to get any medical care is for the patient to pay for it, or have it come through physicians employed by the hospital. This is what the medical profession must face.

We are reminded of what happened in England. The government proposed to the British Medical Association that it buy the practices of the doctors and have the doctors work for the government on a quota basis. Only 17 per cent of the members of the British Medical Association voted yes, so the doctors thought they were safe. The Government went to these 17 per cent and offered to buy their practices; it also bought any other practices which were for sale. The Government wound up with about 40 per cent and started its program. The doctors were in it without their consent and in spite of their negative vote. We hope that is not attempted here.

Public Relations

There was a tense feeling in New York. The medical profession is on trial; it must take care of senior citizens over sixty-five in some way. We have the answer. The Kerr-Mills Bill will do it except in a few limited areas, but our doctors must see that these people do not suffer. The doctors must make certain that the public in general gets a little more favorable concept of the profession than now seems to be developing. The individual doctor seems to be well liked by his patients but they feel the whole profession is worthy of condemnation. If we wish to retain and continue in private practice, all of our doctors must make every effort to make a favorable impression on the public in general. In Michigan, we have just gone through another course of searching inquiry and criticism, hunting for things to complain about, incident to a re-adjustment of Blue Shield rates. That is now accomplished.

The Michigan Insurance Commissioner complained that many doctors overcharged, accepting the Blue Shields rates as part payment only, and made other charges. Michigan Blue Shield was set up originally and continues to be a service program to give complete care for those under income limit. During the years, it has been suggested that doctors, when caring for their Blue Shield patients, discuss with them extra charges if they are over income limit, or if extra charges are contemplated. With such understanding, there can be no justification for much of the generalized criticism which was again made about the profession during the hearings before the Insurance Commissioner.

The feeling in New York at the AMA Conference was serious, that if medical men value their independence, they must follow strictly the principles of ethics long ago established and adopted by all doctors. If good ethics and good will procedures are followed and we still are compulsorily taken over by government, the profession must remember what happened in England. We have been warned.

Acknowledgment

We wish to express our sincere thanks to Dr. Robert J. Crossen of Detroit for his excellent assistance in the preparation of papers for the August number of THE JOURNAL which is devoted to Ophthalmology.

OUTLINE OF 1961 ASSEMBLY AND SECTION SPEAKERS—96TH ANNUAL SESSION MSMS

Grand Rapids, September 27-28-29, 1961

ASSEMBLY TALKS

Wednesday September 27, 1961

9:00-9:30 a.m.
Medicine
ALEXANDER B. GUTMAN, M.D.
New York, New York

9:30-10:00 a.m.
Medicine
JOSEPH V. MESSER, M.D.
Boston, Mass.

10:00-11:00 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00-11:30 a.m.
Medicine
JOHN H. MOHER, M.D.
Philadelphia, Pa.

11:30-12:00 noon
Public Health and Preventive Medicine
JEREMIAH STAMLER, M.D.
Chicago, Ill.

12:00-12:30 p.m.
Obstetrics-Gynecology
ROBERT B. GREENBLATT, M.D.
Augusta, Ga.

12:30-2:00 p.m.
Luncheon (See Section Meetings)

2:00-3:00 p.m.
Dermatology-Syphilology
MARCUS R. CARO, M.D.
Chicago, Ill.
and
JOHN R. HASERICK, M.D.
Cleveland, Ohio

3:00-4:00 p.m.
INTERMISSION TO VIEW EXHIBITS

4:00-4:30 p.m.
Obstetrics-Gynecology
MITCHELL J. NECHTOW, M.D.
Chicago, Ill.

4:30-5:00 p.m.
Obstetrics-Gynecology
SAUL B. GUSBERG, M.D.
New York, New York

5:00-5:30 p.m.
Urology
CLARENCE V. HODGES, M.D.
Portland, Oregon

Thursday September 28, 1961

9:00-9:30 a.m.
Surgery
LAWRENCE G. HAMPSON, M.D.
Quebec, Canada

9:30-10:00 a.m.
Surgery
CUSHMAN D. HAAGENSEN, M.D.
New York, New York

10:00-11:00 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00-11:30 a.m.
Surgery
ANGUS D. MCLACHLIN, M.D.
Ontario, Canada

11:30-12:00 noon
Surgery
WM. ALTEMEIER, M.D.
Cincinnati, Ohio

12:00-12:30 p.m.
Anesthesiology
WM. S. DERRICK, M.D.
Houston, Texas

12:30-2:00. p.m.
Luncheon (See Section Meetings)

2:00-2:30 p.m.
Ophthalmology
BRADLEY R. STRAATSMA, M.D.
Los Angeles, Calif.

2:30-3:00 p.m.
Otolaryngology
FRANK D. LATHROP, M.D.
Boston, Mass.

3:00-4:00 p.m.
INTERMISSION TO VIEW EXHIBITS

4:00-4:30 p.m.
Radiology
GWILYM S. LODWICK, M.D.
Columbus, Mo.

4:30-5:00 p.m.
Gastroenterology-Proctology
HYRUM R. REICHMAN, M.D.
Salt Lake City, Utah

5:00-5:30 p.m.
Occupational Medicine
LEMUEL C. MCGEE, M.D.
Wilmington, Del.

Friday September 29, 1961

9:00-11:30 a.m.
Nervous and Mental Diseases and General Practice
WINSLOW G. FOX, M.D.
Ann Arbor, Mich.
IVAN C. BERLIEN, M.D.
Miami, Fla.
THEODORE A. WATTERS, M.D.
New Orleans, La.

10:00-11:00 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00-11:30 a.m.
(continuation of above panel)

11:30-12:30 p.m.
Pediatrics
JAMES L. WILSON, M.D.
Ann Arbor, Mich.
J. ROSWELL GALLAGHER, M.D.
Boston, Mass.
CARL P. HUBER, M.D.
Indianapolis, Ind.

12:30-1:00 p.m.
FINAL INTERMISSION TO VIEW EXHIBITS

(See Section Meetings)

MEETINGS OF MSMS SECTIONS

Wednesday September 27, 1961

12:00 noon luncheon-meeting
Section on Dermatology-Syphilology
E. RICHARD HARRELL, M.D.
Ann Arbor, Mich.
MARCUS R. CARO, M.D.
Chicago, Ill.
JOHN R. HASERICK, M.D.
Cleveland, Ohio

5:30 p.m. meeting
Section on General Practice
MITCHELL J. NECHTOW, M.D.
Chicago, Ill.

12:30 p.m. luncheon-meeting
Section on Gynecology-Obstetrics
NORMAN F. MILLER, M.D.
Ann Arbor, Mich.
MITCHELL J. NECHTOW, M.D.
Chicago, Ill.
ROBERT B. GREENBLATT, M.D.
Augusta, Ga.
SAUL B. GUSBERG, M.D.
New York, N. Y.

5:30 p.m. meeting-reception
Section on Internal Medicine
RICHARD J. BING, M.D.
Detroit, Mich.

12:00 noon luncheon-meeting
Section on Public Health and Preventive Medicine
JEREMIAH STAMLER, M.D.
Chicago, Ill.

5:30 p.m. meeting-reception-dinner
Section on Surgery
LESTER P. DODD, LL.B.
Detroit, Mich.

5:30 p.m. meeting
Section on Urology
CLARENCE V. HODGES, M.D.
Portland, Ore.

Thursday September 28, 1961

5:30 p.m. reception-dinner-meeting
Section on Anesthesiology and Michigan Society of Anesthesiologists
WM. S. DERRICK, M.D.
Houston, Texas

6:00 p.m. reception-dinner-meeting
Section on Gastroenterology-Proctology
HYRUM R. REICHMAN, M.D.
Salt Lake City, Utah

5:30 p.m. reception-dinner-meeting
Section on Nervous and Mental Diseases and Michigan District Branch of American Psychiatric Association and Michigan Society of Neurology and Psychiatry
IVAN C. BERLIEN, M.D.
Miami, Fla.

5:30 p.m. meeting-reception
Section on Occupational Medicine
LEMUEL C. MCGEE, M.D.
Wilmington, Del.

5:30 p.m. meeting
Section on Ophthalmology
BRADLEY R. STRAATSMA, M.D.
Los Angeles, Calif.

5:30 p.m. meeting-reception-dinner
Section on Otolaryngology
FRANK D. LATHROP, M.D.
Boston, Mass.

5:30 p.m. meeting
Section on Radiology
GWILYM S. LODWICK, M.D.
Columbus, Mo.

Friday September 29, 1961

2:00-5:00 p.m. meeting
Sections on Pathology and Radiology and Michigan Pathological Society
ERNEST E. AEGERTER, M.D.
Philadelphia, Pa.
and
GWILYM S. LODWICK, M.D.
Columbus, Mo.

6:00 p.m. reception-dinner-meeting
Section on Pediatrics and Michigan Branch, American Academy of Pediatrics
J. ROSWELL GALLAGHER, M.D.
Boston, Mass.

Michigan State Medical Society

The Ninety-Sixth Annual Session

Pantlind Hotel-Civic Auditorium, Grand Rapids
September 27-29, 1961

Meetings of Special Societies and Sections

WEDNESDAY, SEPTEMBER 27

The MSMS Section on Dermatology and Syphilology will meet at 12:00 noon for luncheon in the Schubert Room of the Pantlind Hotel, Grand Rapids. There will be a panel presentation on "Serendipity Conference" moderated by E. Richard Harrell, M.D., of Ann Arbor. The panelists are Marcus R. Caro, M.D., Chicago, and John R. Haserick, M.D., Cleveland.

The MSMS Section on Obstetrics and Gynecology will meet for luncheon at 12:30 p.m. in the Continental Room of the Pantlind Hotel, Grand Rapids. The program will be a panel discussion on "Carcinoma of the Fundus" moderated by Norman F. Miller, M.D., Ann Arbor. The other participants are Robert B. Greenblatt, M.D., Augusta, Georgia; Saul B. Gusberg, M.D., New York City; and Mitchell J. Nechtow, M.D., of Chicago.

The MSMS Section on Public Health and Preventive Medicine will sponsor a 12:00 noon luncheon-meeting in the Sadler Lounge of the Pantlind Hotel, Grand Rapids. The speaker is Jeremiah Stamler, M.D., of Chicago, who will talk on "Development of a Heart Disease Control Program in a Local Board of Health."

The Michigan Chapter of the Committee on Trauma, American College of Surgeons, will meet at 12:30 p.m. for luncheon followed by an afternoon meeting and dinner.

Afternoon Session

P.M.

12:30 Luncheon at the Peninsular Club, Grand Rapids, followed by meeting in the Schubert Room of the Pantlind Hotel

2:00 to 3:00 "Mechanical Hyperventilation as a New Treatment of Crushing Injuries of the Chest"
E. Trier Moersch, M.D.
Discussers: Leo J. Kenney, M.D., Grand Rapids—"Experiences with the Moersch Respirator in Non-traumatic Cases"
Clare E. Basinger, M.D., Grand Rapids — "Experience with the Moersch Respirator in the Injured Patient"

3:00 *Intermission*

3:15 "Trimalleolar Fractures of the Ankle"—Harvey M. Andre, M.D., Grand Rapids

3:30 "The Amputee"—Alfred B. Swanson, M.D., Grand Rapids

3:45 "Burn Therapy"—Ralph Blocksma, M.D., Grand Rapids

The MSMS Section on Urology will meet at 5:30 p.m. in Room 124 of the Pantlind Hotel. Speaker is Clarence V. Hodges, M.D., Portland, Oregon, on "Repair of Ureteral Injuries."

The MSMS Section on Internal Medicine will meet at 5:30 p.m. followed by a reception in Room 222 of the Pantlind Hotel. Speaker is Richard J. Bing, M.D., Detroit, on "Coronary Heart Disease and the Regulation of the Coronary Circulation in Man."

The MSMS Section on General Practice will meet at 5:30 p.m. in Room 327 of the Pantlind Hotel. Speaker is Mitchell J. Nechtow, M.D., Chicago, who will talk on "Office Gynecology."

The MSMS Section on Surgery will meet at 5:30 p.m. for reception, dinner, and meeting, in the Sadler Lounge of the Pantlind Hotel. Lester P. Dodd, LL.B., Detroit, will talk on "Guaranteed Procedures for Inviting Malpractice Suits."

The Michigan Orthopaedic Society will meet at 5:30 p.m. for reception, dinner, and evening program at the Peninsular Club. Speaker will be Paul R. Lipscomb, M.D., Mayo Clinic. The title of his paper is "Unsolved Problems of Tendons and Their Environs." All interested physicians are invited; make reservations through George T. Aitken, M.D., 50 College Avenue, S.E., Grand Rapids.

The Michigan Society of Obstetricians and Gynecologists will meet at 5:30 p.m. for reception, dinner and evening program in the Continental Room of the Pantlind Hotel. The after dinner speaker will be Wm. N. Hubbard, M.D., Dean of the University of Michigan Medical School.

All members of the Michigan State Medical Society and their wives are cordially invited to attend this dinner and to hear Dean Hubbard's address. For reservations, write John E. Clifford. M.D., 2108 David Broderick Tower, Detroit 26, and enclose check for $6.00 per person or $12.00 per couple.

The Michigan Chapter of the American College of Chest Physicians will meet at 6:30 p.m. for a reception and dinner-meeting in Room 328 of the Pantlind Hotel.

THURSDAY, SEPTEMBER 28

The MSMS Section on Occupational Medicine will meet at 5:00 p.m. for a meeting and reception, Rooms 322 and 324 of the Pantlind Hotel. Speaker is Lemuel C. McGee, M.D., of Wilmington Delaware, who will talk on "Trends in Health Programs for Employees."

The MSMS Section on Radiology will meet at 5:30 p.m. in Room 222 of the Pantlind Hotel. Gwilym S. Lodwick, M.D., of Columbus, Missouri, will present "Computer Diagnosis in Radiology."

The MSMS Section on Ophthalmology will meet at 5:30 p.m. in Room 328 of the Pantlind Hotel. Bradley R. Straatsma, M.D., of Los Angeles, will present "Melanotic Epibulbar Tumors."

The MSMS Section on Otolaryngology will meet at 5:30 p.m. in Room 323 of the Pantlind Hotel. Speaker is Frank D. Lathrop, M.D., of Boston, on "Parotid Gland Tumors." This meeting will be followed by dinner at an outside club.

The MSMS Section on Gastroenterology and Proctology will meet at 6:00 p.m. for reception, dinner and evening program at the Peninsular Club. Speaker is Hyrum R. Reichman, M.D., Salt Lake City, who will talk on "Treatment of Diverticulitis."

The MSMS Section on Anesthesiology and the Michigan Society of Anesthesiologists will meet in the

Aloha Room of the Pantlind Hotel at 5:30 p.m. for reception, dinner, and evening program. Wm. S. Derrick, M.D., of Houston, Texas, will present "Anesthesiology and the Texas Medical Center in Houston."

The MSMS Section on Nervous and Mental Diseases and the Michigan District Branch of the American Psychiatric Association and the Michigan Society of Neurology and Psychiatry will meet at 5:30 p.m. for reception, dinner, and evening meeting, in the Schubert Room of the Pantlind Hotel. Ivan C. Berlien, M.D., of Miami, Florida, will present "Psychic Energy."

The Michigan Diabetes Association will meet at 6:00 p.m. for reception, dinner, and evening program, in the Apache Room of Win Schuler's Restaurant, Grand Rapids. Solomon A. Berson, M.D., Chief, Radioisotope Service, Veterans Administration Hospital, Bronx, New York, will talk on "Plasma Insulin Concentrations in Man."

The Michigan Chapter, Flying Physicians Association, will hold a luncheon-meeting at 12:15 p.m. in the Schubert Room of the Pantlind Hotel.

FRIDAY, SEPTEMBER 29

The Michigan Pathological Society will hold a business meeting at 10:00 a.m. in the Schubert Room of the Pantlind Hotel.

The MSMS Section on Pathology and the MSMS Section on Radiology, and the Michigan Pathological Society will meet from 2:00 to 5:00 p.m. in the Schubert Room of the Pantlind Hotel. The program will be a seminar on "Bone Tumors." Moderator is Ernest E. Aegerter, M.D., of Philadelphia, and panel participant will be Gwilym S. Lodwick, M.D., of Columbus, Missouri.

The MSMS Section on Pediatrics and the Michigan Branch of the American Academy of Pediatrics will meet at 6:00 p.m. for reception, dinner, and evening program in the Sadler Lounge of the Pantlind Hotel. Speaker is J. Roswell Gallagher, M.D., of Boston, who will talk on "The Adolescent and Our Society."

The Wayne State University College of Medicine Alumni Association will maintain a headquarters suite in the Pantlind Hotel during the MSMS Annual Session. All alumni, faculty, and friends of Wayne State University are cordially invited to visit their hospitality room.

The Annual Session of the Woman's Auxiliary to the Michigan State Medical Society will convene at the Pantlind Hotel, Grand Rapids, September 26-28. Registration will open on the Muzak Mezzanine at noon on Tuesday, September 26, at which time the Hospitality Room will also open in Parlor A.

Arrangements have been made for the furniture showrooms in the Exhibitors Building, just across the street from the Hotel, to be open on September 26 only from 10:00 a.m. to 12:00 noon and from 2:00 to 4:00 p.m. No tickets will be needed for admittance. Members of the Kent County Medical Auxiliary will serve as hostesses and will be in the building lobby to greet you and answer your questions. Visitors will be permitted to roam at will.

The Annual Meeting will commence at 9:30 a.m. on Wednesday, September 27, and at 9:00 a.m. on Thursday, September 28. The earlier-than-usual-opening hours reflect the decision to dispense with the Wednesday afternoon meeting; the Past Presidents' luncheon will be the final program of the day on Wednesday, September 27.

At the Wednesday luncheon, a fashion show will be presented by M. Morgan and with ten auxiliary members modeling.

It is hoped that each Auxiliary member will realize that she is urged to attend this annual program. Every effort is being made to offer an interesting and informative convention and an entertaining one as well.

MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

Occidental Hotel, Muskegon

TUESDAY, SEPTEMBER 26, 1961

P.M.

8:00 Hospitality Room—Courtesy of Muskegon County Medical Auxiliary—Mezzanine

WEDNESDAY, SEPTEMBER 27, 1961

Morning Session

A.M.

9:00 Registration—Chairman, Miss Jenice Lupien—Mezzanine

10:00 "Welcome," Mrs. Betty Lou Willey, President of MSMAS—Ballroom
Business Meeting—Members only
For non-members—Film, "A Calf, An Egg, and a Horse," courtesy of Eli Lilly Co.—Russet Room

11:30 View Exhibits—Convention Room

Afternoon Session

P.M.

12:30 Luncheon—Ballroom
Hostess—Mrs. Julia Irwin
Speaker: Dr. Donald Bouma, Sociology Professor at Western Michigan University, Kalamazoo
Topic: "The Importance of People"

2:00 Detective George Kerr of Michigan State Police Rackets Squad—Ballroom
Topic: "Narcotics—Office Rules and Regulations"

3:00 Film, "Assist for the Medical Assistant"—Ballroom—Panel discussion following film

4:00 View Exhibits—Convention Room

Evening Session

6:30 Social Hour—Courtesy of Medical-Dental-Hospital Bureau—Mezzanine and Palm Room
Music by Hammond Organ Company

7:30 Banquet—Hostess: Miss Donna Hislop
Speaker: Mr. Donald Hall, Department of Trade and Guest Relations of Upjohn Company
Topic: "Ethics for the Medical Assistant"
Dinner Music by Hammond Organ Company

THURSDAY, SEPTEMBER 28, 1961

Morning Session

10:00 *Speaker:* Harold E. DePree, M.D.—Ballroom
Topic: "Cardiac Catheterization"

11:00 *Speaker:* Edward Heneveld, M.D.—Ballroom
President-Elect of Muskegon County Medical Society
Topic: "Experience with the Kerr-Mills Bill"

Afternoon Session

P.M.

12:30 Presidents Luncheon—Ballroom
Hostess: Miss Catherine LaPres
Installation of New Officers
Presentation of Certificates for In-Service Training Program
Presentation of Charters
Style Show—Fashions for the Medical Assistant—Courtesy of Grossman Department Store

2:30 View Exhibits—Convention Room

Please mail check or money order with reservation for luncheons and banquet to: Miss Donna Hislop, 878 Second St., Muskegon, Michigan.

DEADLINE FOR RESERVATIONS: September 15, 1961. No refunds on any reservations canceled after Tuesday, September 26, 1961.

Wednesday Luncheon (tax and tip included)	$ 2.75
Wednesday Banquet (tax and tip included)	5.25
Thursday Luncheon (tax and tip included)	2.75
Registration fee for non-members	5.00

Annual Reports

ANNUAL REPORT OF THE COUNCIL, 1960-61

The Council met as a whole nine times during the past year, covering twelve days of meetings (prior to September 25, the date the 1961 Annual Session convened.) Some 950 items were considered by the full Council.

Membership

Membership as of June 30, and as of December 31, from 1935 to 1961 is indicated in the following chart:

	1935	1945	1955	1958	1959	1960	1961
June 30	3,410	4,425	5,503	6,175	6,461	6,660	6,639
December 31	3,543	4,686	6,109	6,638	6,652	6,714	

The Scientific Side

The scientific achievements of the Michigan State Medical Society continue to be its greatest benefit to MSMS members and through them its greatest service to the public. During the past year, these scientific activities included:

(a) The outstanding program of the MSMS 1960 Annual Session, which in Detroit last September, attracted a registration of 4,094 including 2,266 M.D.s.

(b) No Michigan Clinical Institute was better received by the medical profession of Michigan and neighboring states than the 1961 refresher course held in Detroit last March. Attendance was 2,626 including 1,450 M.D.s (190 more M.D.s than at the 1960 MCI). Attendance at the closed circuit color television programs was eminently satisfactory to the MCI Committee and to Smith, Kline & French Laboratories, the sponsors; also attendance at the 8:00 a.m. Discussion Groups was far greater than anticipated.

(c) The extra-mural postgraduate courses, sponsored by the Michigan State Medical Society, the University of Michigan Medical School and Wayne State University College of Medicine, continue to help maintain the Society's high scientific standing among the states.

(d) THE JOURNAL of the Michigan State Medical Society holds its position as a leader among state medical journals and is truly a scientific publication of distinct merit.

(e) The Presidents Program, approved by the 1960 House of Delegates, includes numerous scientific impacts on the medical profession, on other scientific societies affiliated with or ancillary to the Michigan State Medical Society, which are for the benefit of better health of the people. The impact of this five-year program is one that will be felt gradually, with the effort culminating in 1965 coincident with the One-Hundredth Anniversary of the founding of the Michigan State Medical Society.

(f) The 55 component societies are again commended for their quality scientific programs held at regular meetings, and especially at special clinics and other types of scientific "days."

Finance

The new headquarters building is completed and the contractor and architect are paid except for a retainage pending final adjustments. The former building at 606 Townsend has been sold at a slight gain over its value as carried on our books.

We have one note of $50,000.00 at present but expect to borrow $150,000.00 more by the end of the year. We have saved $1,600.00 in interest by paying off two notes as dues accumulated.

The Public Relations Account has a reserve of $35,000.00 in Government Bonds; however, the emergency meeting of the House of Delegates in April of this year authorized the spending of $10,000.00 of this amount.

The General Fund Reserve of approximately $22,000.00 in Government Bonds is being maintained for emergencies.

The amount of $15.00 of the dues of each member will be allotted to the New Headquarters as directed by the House of Delegates. This should result in retirement of our indebtedness in *five to six years.*

Most of our committees are well within their budgets to date but THE JOURNAL is expected to show a loss due to reduced advertising. Economy is being practiced by all departments.

The Journal

In 1960, THE JOURNAL of the Michigan State Medical Society completed Volume 59, a total of 700 issues, the first volume having been started in September and thus having only four issues. Occasionally during recent years, THE JOURNAL has adopted a new form or arrangement and for the last two or three years has been undergoing a gradual change in appearance, type faces and forms. The size has remained the same. In early years, securing original papers was a serious problem. It had been anticipated that the papers read at the Annual Meeting and some of those read at the County Society meetings would supply sufficient material, but that did not prove out. Sometimes the editorial staff had to solicit papers by personal effort.

About fifteen years ago we had the idea to

devote certain numbers of THE JOURNAL to some special interest. We started producing memorial numbers for two or three of our members, also honoring the University of Michigan and Wayne State University as medical education centers, and asked them to contribute articles to our designated issues. This interest spread to tuberculosis, cancer, rheumatism and arthritis, mental health, also to various county societies such as Wayne, Washtenaw, Kent, Genessee, the Coller-Penberthy Clinic at Traverse City, the Upper Peninsula Medical Society. We have continued that program and find that it produces all the material we could use.

At a conference of editors about a year ago, one of the top questions of discussion was how to secure original articles for state medical journals and other district or specialty journals. In Michigan we have been blessed with an abundance of material. During the year 1960, THE JOURNAL published 1,912 pages of text and advertising, also three supplements: the Roster of Committee Personnel (8 pages), the Proceedings of the House of Delegates at its September meeting (76 pages) and the Annual Directory (148 pages) making a grand total of 2,144 pages.

In the late summer of 1960, it became evident that we must curtail expenses, because the advertising which we had been depending upon for so many years began to fall off—about 37 per cent in the latter months of the year. At that time we began curtailing the extensive reports and many of the original articles, hoping this period would be temporary. We cut down the size of THE JOURNAL by 24 pages or more.

In 1960. we had a total of 202 authors and published numerous items, Society reports, special reports, 58 editorials and 28 editorial comments, 16 legal opinions and 11 presidential pages. Most of the individual numbers were sponsored by or dedicated to specific interests of the Society; they were Congestive Heart Failure, Michigan Health Council, Memorial to L. Fernald Foster, M.D., Cancer, Aging, Michigan Medical Service, Annual Session, The Kalamazoo Academy of Medicine, Mental Health, Diabetes, Heart, Child Welfare, and Mental Retardation.

The January 1961 number was devoted to the Michigan Clinical Institute. In addition to the programs, we had the supplement of the Proceedings of the House of Delegates and the Supplement Roster of the Committees. J. P. Gray, M.D., of Detroit, with his Committee spent many months assembling material of the February issue devoted to Medical Writing. The Committee studied every paper and sent it to the editor almost completely edited. March was Arthritis and Rheumatism, and J. J. Lightbody, M.D., of Detroit, secured an abundance of material for us. H. J. Vandenberg, Jr., M.D., Detroit, assisted in developing the material for the April Cancer Number. The May JOURNAL was devoted to the dedication of our new headquarters building in Lansing. For the Michigan Medical Service issue in June, G. Thomas McKean, M.D., and Gordon Goodrich and their staff supplied the technical material. The June Number was the culmination of 13 years in which this particular Number has been devoted to Michigan Medical Service. The July issue was devoted to the Annual Session. August was devoted to Ophthalmology; Robert Crossen, M.D., Detroit, assembled much fine material for that issue. September was assigned to Otolaryngology and V. E. Cortopassi, M.D., Saginaw, has assisted in gathering that material. October will be devoted to Aging and in November, John Bielawski, M.D., Detroit, will again assist us with the Heart Number. The December 1961 Number will be devoted to the Calhoun County Medical Society.

We have been made aware of the very material shrinkage of our advertising space. Immediate compacting is almost impossible. All of these special numbers mentioned are under way and require months of work by our coordinators in assembling papers. The finished papers must go to the printers 60 days before THE JOURNAL date number. We have three numbers in process at all times and material for at least three more is accumulating. We are making every effort, however, to get the best material possible and hold THE JOURNAL down as closely as we can to a proper balance of advertising and text pages. This will be difficult because during the years we have developed a feeling that we could use many papers, and have accepted many for publication when and if we could use them. Cutting down will be difficult and we hope not too embarrassing. We have already declined several very promising papers and sent some others back to be reduced in size.

We wish to thank the Publication Committee for its cooperation and sympathetic assistance in the many problems which must be solved. The work has been enjoyable and stimulating. We also wish to thank the coordinators of our various numbers who have given tremendous help in our work.

Organization

1. Communication between The Council and members of the House of Delegates was continued mainly through Councilor Conferences and through the mailing of minutes of all Council meetings to those Delegates who requested them.

Recommendation No. 1 on this subject follows.

2. The Awards Dinner was held in Lansing on January 28, 1961 to recognize national medical and health leaders as well as organizations in Michigan which contributed outstanding service to better health for the citizens of this State. The awardees were:

Charles H. Frantz, M.D. Grand Rapids, Presi-

dent, Clinical Orthopedic Society; Martin H. Hoffman, M.D., Detroit, President, Central Neuropsychiatric Association; C. Paul Hodgkinson, M.D., Detroit, President, American College of Obstetricians and Gynecologists.

Mrs. Wm. G. Mackersie, Detroit, President, Woman's Auxiliary to American Medical Association.

Radio Station WUOM, Ann Arbor, for programming special public service broadcasts on health subjects; Jackson Citizen Patriot for excellent cooperation with Jackson CMS, AMA, etc., in printing medical news.

Jack Pickering for many years of excellent reporting medical news for *Detroit Times;* Dirk Gringhuis, Lansing, artist, for his excellent work on JMSMS covers; Marvin Niehuss, Ann Arbor, for rendering service to the University of Michigan School of Medicine—as Dean of Faculty, University of Michigan and President of the Michigan Health Council; Charles R. Sligh, Jr., Holland, Chairman of the Board of the Deafness Research Foundation.

3. The annual County Secretaries-Public Relations Seminar was held in Lansing on January 28-29, 1961. A total of 138 county and state society officers attended this worthwhile leadership-training meeting at which valuable information on socio-economic matters was imparted.

4. The Residents-Interns-Senior Medical Students Conference was featured on March 9 during the Michigan Clinical Institute. The Council has authorized a reappraisal of this Conference with a view to reaching more of the future doctors of the State.

5. General meeting at Annual Session. A short General Meeting of the Society entitled "Officers Night" held at the last meeting of the House of Delegates in September, 1960—at which time the incoming President was inducted into office—was a decided improvement in the organization of MSMS, and should be continued.

Recommendation No. 2 on this subject follows.

6. New Handbook for component societies' secretaries. This worthy publication, listing the responsibilities and opportunities of secretaries of component societies, was developed during the past year to complement the previous MSMS manual "So You've Been Elected." Distribution of the Secretary's Handbook was made at the County Secretaries-Public Relations Seminar in January, 1961. A special luncheon for new secretaries was held immediately prior to the opening of the Seminar.

7. The Relative Value Scale for Michigan was presented to The Council on July 12, 1961, after three years' study. Special commendation goes to the RVS Committee for its industry and high devotion to duty. The personnel includes: L. R. Leader, M.D., Detroit, Chairman; F. C. Brace, M.D., Grand Rapids; H. T. Caumartin, M.D., Saginaw; A. J. Day, M.D., Grosse Pointe Farms; H. A. Furlong, M.D., Pontiac; R. A. Johnson, M.D., Detroit; and A. J. Neerken, M.D. Kalamazoo.

Recommendation No. 3 on this subject follows.

8. Articles unfavorable to Medicine, appearing in increasing number in magazines across the land, were discussed by The Council which sought advice from the AMA. When unfavorable articles appear, AMA protests generally are made face to face with the editors involved as well as through letters signed by AMA officials. Since an increase in the number of articles involving medicine can be expected because of the present spotlight involving health care of the aged, The Council feels that protests also should come from our own Society and its important "grass roots."

Recommendation No. 4 on this subject follows.

9. Other organizational improvements inaugurated during the past year were: American Medical Education Foundation awards of merit were sent to the appropriate component societies for presentation to members; AMEF checks to the two medical schools in Michigan were presented through the Michigan State Medical Society at the June 4 dedication of the new MSMS building; the Advisory Committee to the Executive Director was made a standing Committee of The Council in November, 1960; and index of The Council's major actions, in addition to the current cataloging of policy decisions, was inaugurated during the past year; Council proceedings were expedited during the past year by mimeographing some of the Officers' and staff members' reports, and a plan was developed to expedite agenda presentations to keep pace with the increased business placed before The Council (an indication of the greater scope of activity of your State Society); the Directory of Members is to be published biennially, in the even numbered years, to save expense.

10. Obtaining speakers for component society meetings, giving guidance on scientific, legal and socio-economic questions, and helping to solve administrative and ethical problems continue to be important services which the State Society is rendering to its 55 components.

Contacts with Governmental and Voluntary Agencies

The maintenance of contacts with both governmental and voluntary agencies represents a major and important department of your State Society's work.

Governmental Agencies

1. The University of Michigan's Study of Hospital and Medical Economics, including Blue Cross and Blue Shield (the McNerney Report), financially sponsored by the Kellogg Foundation at a cost of $380,000, was completed recently after more than three years' work. This subject was considered at every meeting of The Council during

the past year. The Council requested that a copy of the information released to the Governor's Commission be released simultaneously to the Michigan State Medical Society as well as to the Michigan Hospital Association, Michigan Hospital Service, Michigan Medical Service, and others. The Education Liaison Committee was urged to do all in its power to implement necessary follow-through to secure prompt release of this report to MSMS members.

The Medical Care Study Committee thoroughly considered this matter and stressed the pressing need for MSMS to retain a staff economist and to obtain the services of special consultant economists to evaluate the U-M study. A preliminary evaluation of the two published sections of the report, to ascertain if there is need for a more complete and detailed study, was authorized by The Council on April 19. Professor C. T. Hardwick, Director, Institute for Business Services, University of Detroit, was engaged to develop a report for the July Session of The Council.

Recommendation No. 5 on this subject follows.

2. Health care of the aged. Both the federal and state governments have indicated great interest in this subject during the past year, with gross political connotations apparent before and since the November election. Following the AMA Legislative Conference of March 18-19 in Chicago, The Council called an emergency meeting on March 26 to discuss the implications of HR 4222 in the federal Congress, which proposes health service to the aged through the Social Security System. To develop and implement a necessary informational campaign to the public through MSMS members, The Council requested the Speaker of the House of Delegates to call a special session to consider action on this problem, which Session was held in East Lansing on April 16. As you all know, seven work groups discussed (a) Financing the program; (b) Communicating with doctors; (c) County medical society programs; (d) Media; (e) Legislative contacts; (f) Working with others; and (g) Establishment of position and policy of Michigan Medicine. Each group offered recommendations in its category which, as amended, were adopted by the House of Delegates.

As of the present moment, the situation in Washington has been slightly altered by the House of Representatives insistance that hearings on HR 4222 and similar proposals be scheduled. During this period of momentary "quiet on the western front," your State Society has proceeded with the April 16 House of Delegates plan, including four regional meetings, an information mailing to all MSMS members, preparation of a printed brochure, development of a speaker's bureau, etc. But it is the better part of valor to hold most of the fire until the picture becomes less opaque, until the Washington strategy is more clear. Meanwhile, the Michigan State Medical Society has requested that its representative (O. K. Engelke, M.D.) be invited to present testimony at the hearings in Washington, D. C., and the complete implementation of the House of Delegates program is being scheduled by the Public Relations Committee.

In this connection, The Council feels this is the time we must *accentuate the positive.* Medicine must take the offensive and tell about the fine work of the medical profession—we must be a challenging profession—we must sell medicine—we must contact morale-breaking opponents with dignity, showing them and all others that it is much more difficult to be a doctor of medicine now than formerly and that we have a great profession. We must improve the collective image of the medical profession by aggressive presentation of Medicine's viewpoints.

The good that Medicine has done in its glorious history and is doing today, with the United States offering the best health care in the world, must be expounded over and over and over to the people by doctors and their friends. This profession has everything to be proud of, its accomplishments are glorious, its future bright! No other organized group can claim more, and few can claim as much in the field of service to the public. Further, medical men must realize that the best organizations doctors have to defend Medicine, as we know it, is their county, state, and national societies and must stand unified behind them. *Accentuate the good* that we have and are doing!

Recommendation No. 6 on this subject follows.

3. As in 1960, The Council presented testimony at the Michigan Insurance Commissioner's hearings on Blue Shield's request for a rate increase. Good publicity for the medical profession resulted from the affirmative position taken by the State Society and the presentations made by H. J. Meier, M.D., at the Detroit hearing, February 7, 1961; by Clarence Beets, M.D., at the Grand Rapids hearing, February 15, 1961; and by Kenneth H. Johnson, M.D., at the Lansing hearing, February 16, 1961.

4. White House Conference on Aging. The State Society was ably represented at this Washington, D. C., Conference by Albert E. Heustis, M.D., Lansing; Max K. Newman, M.D., Detroit; C. J. Tupper, M.D., Ann Arbor; V. K. Volk, M.D., Saginaw; H. B. Zemmer, M.D., Lapeer. The determined efforts of proponents of socialized schemes were countered in part by the understanding and skill of Medicine's representatives at this important meeting. The vital value of well informed, well organized effort on the part of Medicine was graphically illustrated at this well publicized Conference.

5. Proposed Institute of Biology and Medicine. The Council's Education Liaison Committee (B. M. Harris, M.D., Chairman) has met on several occasions with Michigan State University representatives who are studying the possibilities of

creating such a two-year Institute on the East Lansing campus. The plan is now in the exploratory stage; new developments as they emerge will be presented to the House of Delegates for its information.

6. The Michigan State Medical Society continues to have beneficial contacts with other governmental agencies including (a) the Michigan Legislature; (b) Michigan Department of Health with Commissioner A. E. Heustis, M.D., invited to all meetings of The Council; (c) Michigan Department of Public Instruction and its Office of Vocational Rehabilitation; (d) Michigan Department of Social Welfare; (e) Michigan State Board of Registration in Medicine; (f) Michigan Crippled Children Commission; and (g) University of Michigan Medical School and Wayne State University College of Medicine with the Deans of each being invited to all meetings of The Council.

Voluntary Agencies

1. Periodic reports on the progress of Michigan Medical Service are made to The Council by MMS President G. Thomas McKean, M.D., Detroit. The new Executive Vice President, Sumner G. Whittier, was introduced to The Council at its March 7 meeting on which occassion the MSMS position with Michigan Medical Service was thoroughly discussed. In essence, The Council feels that the medical profession of Michigan does and must stand behind Michigan Medical Service which is an instrument of good for the people of Michigan; physicians may well ask the question: "Has anything *better* been created?"

2. The American Medical Association continues an aggressive program against proponents for socialized medicine. In a word, all MSMS members should be proud of AMA, willing to work in its ranks and to support it in its efforts for the preservation of medical practice as we know it.

3. Your State Society continues to encourage the Student American Medical Association and urges more individual doctors of medicine to offer guidance, especially in socio-economic matters, to those future physicians of the nation. SAMA has given these young men and women a good foundation in the principles of practice in which we believe; but beneficial contacts with practicing M.D.s is necessary to imprint on their impressionable young minds that a collectivist system of medical service to the people would quickly ruin quality medical care.

4. Statement of policy re podiatry. Recent contacts were made with the Michigan Association of Orthopedic Surgeons and the Detroit Academy of Orthopedic Surgery enlisting their comment re MSMS statement of policy on podiatry which embodies the principles set forth in the statement of the American Academy of Orthopedic Surgery and the Joint Commission on Accreditation of Hospitals. If approved by the Michgan groups, the statements re podiatry will be presented to the House of Delegates for its consideration.

5. Mutually beneficial contacts continue to be maintained with the Michigan Heart Association, Michigan Hospital Association, Michigan State Dental Association, Michigan State Nursing Association, Michigan League for Nursing, Michigan Practical Nurse Association, Michigan State Pharmaceutical Association, Michigan Hospital Service, Michigan Medical Service, Michigan Branch of Health Insurance Council, Michigan Health Officers Association, with the six other Michigan organizations interested in cancer control through the Michigan Cancer Coordinating Committee, Michigan Livestock Health Council (interested in animal diseases communicable to man); Michigan Association of the Professions, and the Michigan Health Council (which is to be especially commended on its excellent health conference held in Flint in May, which on one day featured the MSMS Presidents Program).

Committees

A total of eighty-six meetings of Committees of (a) the House of Delegates, (b) the Michigan State Medical Society, and (c) The Council were held during the past year (up to August 31, 1961). Additionally, twelve meetings of liaison committees to which MSMS sends official representatives, were held during the past year. The structure and activity of your State Society committees continue to be the core of MSMS progress. Committee members, therefore, deserve high praise for their almost anonymous contributions to all MSMS members and through them to the public.

1. Special commendation goes to the Big Look Committee which successfully guided the erection of the new MSMS headquarters building in East Lansing—the zeal of Chairman W. S. Jones, M.D., of Menominee and MSMS President K. H. Johnson, M.D., of Lansing, must be recognized.

2. The increasing importance of the Committee on Recruitment for Medical Careers, headed by Glenn E. Millard, M.D., of Detroit, exemplifies the high interest of your State Society in finding the best qualified young men and women to enter the medical field. Several MSMS representatives participated with the Michigan School Counselors Association in a Career Information Workshop, July 7-8 at Alma College. Here is an opportunity for every member of the Michigan State Medical Society, especially the members of the House of Delegates, to give tangible help. The quality of those seeking a career in Medicine is now as good as ever but the numbers are not as generous as ten years ago, due in part to the recent glamour of other scientific callings. Grass root contacts by individual M.D.s is necessary to maintain Medicine's place in the career's sun.

3. To save time for members of the House of Delegates Reference Committees, the Annual Reports of Committees of The Council are annually

integrated into this report of The Council:

A. *Big Look Committee.*—As in previous years, the Big Look Committee continued to supervise the construction and furnishing of the new MSMS headquarters as instructed by The Council.

Continuing liaison with the architect, the general contractor and various subcontractors was maintained by various members of the Committee, especially Kenneth H. Johnson, M.D., of Lansing, who was appointed Lansing contact representative of the Committee.

Between President Johnson and the Chairman, many decisions of the Committee were resolved by consultation through letter and telephone during the year.

On January 28, 1961, in East Lansing, the Big Look Committee held its one formal meeting to develop specific plans and program for the dedication ceremony which was subsequently held on Sunday, June 4, 1961.

The Committee emphasized that the dedication, printed program and the presentations by officers of the Society should emphasize the doctors' desire to serve the people of Michigan and that this service could be increased through the use of the new and functional MSMS headquarters.

As one of its last duties, members of the Committee, on June 4, gave a final inspection to the headquarters building and the resulting comments were submitted to the architect for any necessary action by the general contractor.

Having fulfilled its purpose and completed its work, the Big Look Committee respectfully recommends that it be discharged.

The Chairman wishes to extend special thanks to each member of the Committee who so faithfully and conscientiously served in behalf of all Michigan State Medical Society members.

B. *Michigan Chairman, American Medical Education Foundation.*—Again this year, the Michigan State Medical Society's dues notice sent to all members contained a request for a voluntary contribution to the American Medical Education Foundation.

In addition, the American Medical Education Foundation sent a direct appeal for contributions to every member of the American Medical Association in May, 1961.

From reports of AMEF and the MSMS, it is obvious that most contributions to AMEF from Michigan physicians and friends of medicine are sent directly to the AMEF in Chicago.

This year, at the dedication ceremonies of the new MSMS headquarters on Sunday, June 4, 1961, at East Lansing, AMEF checks totalling $26,286.54 were presented to the Deans of the University of Michigan Medical School and the Wayne State University College of Medicine. These checks represented contributions from the nation's doctors that were designated to Michigan medical schools, plus undesignated contributions to AMEF which were apportioned equally among all medical schools.

Included in the above totals were contributions of Michigan physicians as a result of the MSMS dues notice appeal. These checks were made out to AMEF, sent to MSMS, and forwarded to the Chicago office. For the period January 1, 1961, through May 30, 1961, 142 members of the Michigan State Medical Society had contributed a total of $1,980 to AMEF through the MSMS office.

The AMEF committees of the Woman's Auxiliary to the MSMS have continued their excellent activity with their contributions going directly to the AMEF.

Your Chairman this year recommended that there be an increase in MSMS dues or an allotment from present dues for a special AMEF fund. This was similar to a resolution placed before the House of Delegates in 1958, which was not adopted, for the House believed that all contributions should be made on a voluntary basis.

Your Chairman is pleased to report that the AMEF checks to Michigan medical schools were given the broadest possible publicity this year, on the occasion of the dedication of the new MSMS headquarters, and recommends that similar public presentations be made in future years as the opportunity presents itself, so that the public may be more aware of the support the physicians of the United States are lending to medical education.

C. *Committee on Disaster Medical Care.*—The appointment of Max Lichter, M.D., to the chairmanship of the American Medical Association Committee on Disaster Care prompted his resignation from the Chairmanship of this Committee in the middle of the year. Doctor Lichter has devoted many years to local, State, and National activities in this field, and his present appointment is highly deserved.

The Committee, in its normal activities, completed plans for a spring tour of components of the 200-bed Emergency Hospital under the joint sponsorship of the Michigan Office of Civil Defense.

By the experience gained in getting the components of the 200-bed Emergency Hospital on the road, the Committee aided the MOCD in getting out a Manual of Instruction in how to open up these hospitals for functional use. This was published by the MOCD in May, 1961.

A periodic civil defense newsletter was prepared and mailed to all of the members. The Committee received information about training courses for nurses in the State in the use of the 200-bed Emergency Hospital. Plans for a civil defense exhibit have been submitted to The Council for approval at the September meeting in Grand Rapids. It also prompted, in coordination with the Michigan State Pharmaceutical Association, a survey of available medical and surgical supplies.

The second Annual Physicians' Hospital Workshop on Civil Defense was held in Battle Creek on May 17 and attended by 102 representatives of local societies and hospitals in civil defense.

D. *Committee on Courses on Medical Economics and Ethics.*—The year has been vigorous

and productive, and we gratefully acknowledge the contributions of our Committee members, visiting dignitaries, lay and professional speakers, the faculties and members of the Senior Medical Class, University of Michigan.

Dr. Richard Bing, this year, is Chairman of the Student Faculty Assembly, Wayne State University College of Medicine, Detroit, and he has kindly volunteered to reflect the work at that school. He has been requested to write you direct.

SCHEDULE OF LECTURES BEFORE THE UNIVERSITY OF MICHIGAN SENIOR MEDICAL CLASS

1. 7/ 6/60 "Development of a Fee Schedule," by C. Howard Ross, M.D.
2. 7/20/60 "The Surgeon and His Fee," by Charles G. Child, M.D.
3. 7/27/60 "The Veterans Problem," by William Bromme, M.D.
4. 8/30/60 "The Morality of Surgery," by Thurston Thieme, M.D.
5. 8/17/60 "Ethics Involved in George Washington's Death," by Darrell Campbell, M.D.
6. 8/31/60 "The Physician's Responsibility to the Community," by Richard C. Bates, M.D.
7. 9/14/60 "Hospital and Medical Economics," by Prof. W. J. McNerney
8. 10/ 5/60 "Ten Easy Lessons on How to Land in Court," by Lester P. Dodd, Attorney, Michigan State Medical Society
9. 10/12/60 "Continuing Education in Medical Ethics and Economics," by William Hubbard, M.D., Dean, U. of M. Medical School
10. 11/16/60 "The Doctor's Accounting System," by C. Howard Ross, M.D.
11. 11/30/60 "The Doctor in Court," by Judge James R. Breakey, Jr.
12. 12/ 7/60 Panel—"Orientation, Between General Practice and the Specialties"
    (a) "Introduction and Moderator," C. Howard Ross, M.D.
    (b) "General Practice and the Specialties," by Howard Robinson, M.D.
    (c) "General Practice in a Metropolitan Area," by Lyle Korum, M.D.
    (d) "Consultation Techniques," by A. C. Stander, M.D.
    (e) "Art of the Practice," by F. P. Rhoades, M.D.
    (f) "The Family Physician's Place in the Community," by Russell Fenton, M.D.
    (g) "General Practice—The Keystone," by Howard Rees, M.D.
    (h) "Medical Organization," by E. Clarkston Long, M.D.
13. 12/14/60 "A History of Ethics," by C. Howard Ross, M.D.
14. 1/18/61 "Michigan State Medical Society," by Otto K. Engelke, M.D., President-Elect, MSMS
15. 1/25/61 "A Doctor Walks Among Many Religions," by Winslow G. Fox, M.D.
16. 2/ 1/61 "An Ethical Approach to Geriatrics," by C. Howard Ross, M.D.
17. 2/ 8/61 "Ethical Relationship Between Public Health and the Practice of Medicine," by Myron Wegman, M.D., Dean, School of Public Health, Univ. of Michigan
18. 3/ 8/61 "The Ethical Problems of Race Explosion, Contraception and Therapeutic Abortion," by Panel: John Sheldon, M.D., William Hubbard, M.D., and David G. Anderson, M.D.
19. 3/ 5/61 "Duo Versus Singleton Practice," by Robert Kanauer
20. 4/ 5/61 "Medical Manpower," by A. C. Furstenberg, M.D., Dean Emeritus, Univ. of Michigan Medical School
21. 4/12/61 "Orientation Committee, Washtenaw County Medical Society," by Panel, conducted by: John M. Sheldon, M.D., Chairman, Edmund S. Botch, M.D., Moderator, R. Wallace Teed, M.D., Theodore G. Kabza, M.D., and Gerhard H. Bauer, M.D.
22. 5/10/61 "Medical Placement in Michigan," by Sidney Chapin, M.D., President, Michigan Health Council, R. W. Spaulding, M.D., John E. Doherty, Executive Secretary, Michigan Health Council
23. 5/17/61 Panel—"Medical Communication and Public Relations"
    (a) "Confidences Between Doctor and Patient," by C. Howard Ross, M.D.
    (b) "Public Relations," by R. Wallace Teed, M.D.
    (c) "Medical Communications," by Mr. Hugh Brenneman
    (d) "A Doctor's Niche in His Own Community," by Stuart M. Finch, M.D.

We had a very good attendance through the entire year and some students took notes for their confreres, who externing elsewhere.

E. *Liaison Committee with Michigan Veterans Organization.*—Only one problem has been presented during the past year. This concerned alleged prescribing for a service-connected condition without authorization by Veterans Administration.

Preliminary study has not warranted a call for a committee meeting.

F. *Committee on the Recruitment of the Superior Medical Students and Their Need for Financial Aid.*—The Committee held one meeting in March of 1961. Prior to this it was a Subcommittee of the Public Relations Committee. The first meeting of the Committee was for the purpose of studying the problem of recruitment on one hand and of financial aid on the other. Invited in the discussion were representatives of the Deans of the two Medical Schools. Our study showed that only six out of the fifty-five county medical societies have any loan or scholarship program.

The Michigan Foundation for Medical and Health Education has so far refused to disclose any details of the amount or number of scholarships which they have. The Deans report that the demand for positions in medical school now is only about equal to the number of positions available, also, that there is a sort of competition developing between the medical schools for exceptional medical students—particularly by the medical schools in the East.

The recommendations following the last meeting of this Committee were:

1. That a letter be prepared under the supervision of the Chairman of this Committee urging each county medical society to set up a scholarship or loan fund and that this be followed by a

letter requesting a personal visit to a meeting of each county medical society by a member of this Sub-committee, a member of SAMA, and when possible, by a representative of the Dean of one of the Medical Schools to assist in the implementation of the formation of this scholarship loan fund on a county basis.

2. The Committee recommends to the Michigan Foundation for Medical and Health Education Incorporated, that a re-study of their loan and scholarship provision be made for the purpose of considering liberalization of these provisions in the area of (a) geographical restriction of applicants, (b) re-payment and (c) rate of interest, (d) ultimate location of practice.

The Committee has the feeling that the alumni societies of the two Medical schools have not done a good job in scholarship and loan programs. A further study is contemplated in this area.

It is obvious that neither the county societies nor the State Medical Society has done a good job in this area.

G. *Committee to Study Problems of Emergency Care in Hospitals.*—The Committee met on May 23, 1961. It was largely an organizational meeting, in which the work of a similar committee of the Wayne County Medical Society was reviewed and this Committee's plans were formulated.

The discussion of hospital emergency care revealed the fact that serious problems exist throughout the state requiring investigation.

The Committee requested The MSMS Council's permission to make a survey of accredited hospitals in the state, through the chiefs of staff, regarding their problems in handling emergency medical care.

If this request is approved by The Council, the Committee will meet to develop a questionnaire.

H. *Medical Care Insurance Committee.*—The MCIC has been mainly concerned during the past year with the report of the Relative Value Study. We have had two joint meetings with the RVS Committee as well as attending the final meeting with all specialty groups.

The Relative Value Study has now been approved and transmitted to The Council for further action. We have also followed closely the predicament of Michigan Medical Service and we are interested in the new contracts which are being considered by the Michigan Medical Service Board of Directors.

Annual Report of Sub-Committee on Relative Value Study, 1960-1961.—Recommendations of the Relative Value Study Sub-Committee are incorporated in the "Proposed Michigan Relative Value Scale" which will be presented to the 1961 House of Delegates.

It was during 1960-61 that the Relative Value Study Sub-Committee completed its work. Organized in December, 1958, the committee met for 34 separate days of meetings and conferences to develop a list of proposed relative values.

After its mail survey in early 1960, an independent, professional analysis organization compiled and tabulated the material. It was certified by a statistical consultant as being valid.

The Committee, using this data, then held hearings and consultations with the officially-chosen representatives of the various general and specialty groups of doctors in Michigan. The tentative RVS report was furnished to all the various medical organizations and an open hearing was held in February, 1961. Some final changes were made and the report was presented to the Medical Care Insurance Committee in April. MCIC presented the report to The MSMS Council in June.

No one on the committee realized how enormous this task would be. In addition to the committee meetings and conferences, many hours were spent on "homework" between sessions. This is mentioned only to indicate the careful analysis and study which was required in this project. Cooperation from individual doctors and from the various medical organizations was excellent.

I. *MSMS Representatives to Liaison Committee with Michigan Society of Neurology and Psychiatry and Michigan Psychological Society.*—There were no meetings held between the Liaison Committee and the Michigan Psychological Society. As indicated in our report last year, the members of this Committee have been kept up-to-date regarding the devolopments in this particular area since we also are members of the MSMS Committee on Mental Health.

Reports of liaison committees, to which MSMS sends representatives, were presented monthly to The Council for its information.

Legal Matters

Your Legal Counsel, Lester P. Dodd, LL.B., of Detroit, attended practically all meetings of The Council and of the House of Delegates and attended and participated in the County Secretaries-Public Relations Seminar, the MSMS Annual Session, and the Michigan Clinical Institute.

Legal Counsel attended many committee meetings and participated actively in the work of the Legal Affairs Committee, the Committee on Utilization of Practical Nurses, all committees pertaining to insurance, and the Committee on Revision of the Constitution and Bylaws (the latter being extraordinarily time consuming). He visited and addressed several county societies and other professional organizations.

Mr. Dodd has done considerable research and investigation with respect to adoption of a single practice act, retirement plans and Kintner-type legislation. He rendered six formal and fifty-six informal opinions on a wide range of subjects. He handled many legal problems arising out of the

construction and furnishing of the new headquarters building.

Finally, Mr. Dodd counselled with officers and staff on innumerable details on the Society's operations.

New MSMS Headquarters Building

At every meeting of The Council, a report on the progress of the new building including furnishings and new equipment, and sale of 606 Townsend in Lansing (sold for cash on May 15, 1961) was presented by the Lansing representative of the Big Look Committee, President Johnson.

The raw building was completed and certified for occupancy by the architect and the Society moved into the headquarters at 120 W. Saginaw Street, East Lansing, on April 24.

Gifts to aid in the furnishing of the building were gratefully received from Mrs. L. Fernald Foster and family of Detroit, in memory of our long-time Secretary, the late L. Fernald Foster, M.D.; from Mrs. Ralph W. Shook and family of Kalamazoo, in memory of our long-time Finance Chairman, the late Ralph W. Shook, M.D.; from Big Look Chairman and Mrs. W. S. Jones, Menominee; from the Past Presidents to decorate the Presidents' Room; from the Woman's Auxiliary to furnish the All Purpose Room; from Bruce Publishing Company of St. Paul; and Wellman Press of Lansing. Small plaques, to memoralize these generous gifts, have been placed in appropriate rooms of the new building.

The dedication of the building on June 4 was a happy occasion, blessed with perfect weather, a large and sparkling attendance, and a ceremony befitting this great occasion. A copy of the dedicatory booklet, including the program of the day, is respectfully submitted with this report.

Every member has reason to be proud of the Michigan State Medical Society and its century of accomplishment, professional dignity, and record of life saving service to mankind—all symbolized in its modern and useful headquarters building in East Lansing, dedicated to the public interest.

MSMS Group Insurance Programs

The Supplemental Annual Report of The Council will contain a complete report on the two group insurance programs of your State Medical Society with data up to September 1, 1961.

"Medicare" and Veterans Administration Hometown Medical Care Programs

1. *Medicare* (Medical care for dependents of servicemen) continues to be handled by Michigan Medical Service as fiscal agent of the Michigan State Medical Society. To date, since the restoration of some services to the program, there has been an increase in the private practice of medicine under the program. The program so far has been satisfactory both to the patients and the doctors. Michigan Medical Service has been commended for its handling of the program. During the fiscal year, $904,846.32 was paid to practicing physicians for service rendered.

2. Veterans Administration Hometown Medical Care Program. During the past year there were no changes made in the program. The contract was extended, with approval of The Council, to June 30, 1962. The Council again, in approving the extension of the contract, indicated its attitude had not changed as reported previously "unless the program for care of veterans is much improved, MSMS seriously considers discontinuing its participation."

There has been a decrease by approximately 25 per cent during the year in the number of invoices received from the Veterans Administration for physicians' services. As a result the total amount of fees for services paid by the fiscal agent has decreased.

Woman's Auxiliary

Submitted by Mrs. Paul Ivkovich, President

The most gratifying of experiences has been to be head of the auxiliary to the finest organization of men . . . the Michigan State Medical Society. During this season of Commencement Exercises, I too feel as though I were graduating after four years of service on the state level to an organization that at first was completely social and now is a most progressive organ of activities.

The Woman's Auxiliary to the Michigan State Medical Society was formally organized June 16, 1927 at Mackinac Island by Doctor Herbert Randall of Flint, then president of the Michigan State Medical Society. Mrs. Guy L. Kiefer, Detroit, was the first president with twenty-eight charter members. Her name is engraved on the official gavel of the president as a token to her memory. Today Michigan has forty-eight organized county auxiliaries, twenty member-at-large among the eight unorganized counties with a total membership of 3,275. This represents approximately half of the membership of the Michigan State Medical Society and it is our sincere hope that we may recruit more doctors' wives to belong to an organization dedicated to serve the finest profession in the world.

We wish to sincerely thank all the members of the Michigan State Medical Society for their cooperation during the past year and tell you how very happy we were to be called upon to work with you. In August of 1960, our county presidents were asked to contact their membership to work on the "Campaign for Freedom" program with you . . . the response was most gratifying. This year as in other years, your auxiliary has worked with the youth in Michigan to encourage them in the health careers. The county reports reveal formation of Future Nurses Clubs, Future Doctors Clubs and now Health Careers Clubs. Auxiliaries throughout the State raise money for scholarships for nurses and to furnish money for future doctors. Alto-

gether close to $6,000.00 has been donated in the form of scholarships and loans to individual students and to schools of nursing and medicine.

Legislation has been our main project this year. We are cooperating with the Woman's Auxiliary to the AMA, headed by our national president, Mrs. William Mackersie of Detroit, Michigan's first national president, in Operation Coffee Cup.

The Michigan State Medical Society has specifically asked the Auxiliary to work on Operation Coffee Cup at their special meeting of the House of Delegates, April 16, in Lansing. This project hinges upon the use of the record, "Ronald Reagan Speaks Out Against Socialized Medicine" in informal groups in individual auxiliary members' homes to stimulate friends and neighbors to write their congressmen. Michigan has one hundred records at this time which are being distributed throughout the State and we are pleased to report that it seems to be going over well . . . even our county medical societies are interested in this record and have used it at their county meetings. The AMA is underwriting the cost of these records. We are not planning to complete Operation Coffee Cup in a month or two months . . . we hope to continue its use for at least a year and feel confident that it will produce fine results.

We are very proud of our activities in the field of raising funds for the American Medical Education Foundation. We have increased this fund from approximately $6,000.00 in 1960 to $9,000.00 in 1961 due to the untiring efforts of our AMEF Chairman, Mrs. Rufus Reitzel of Mt. Clemens. Mrs. Reitzel attended several District Meetings and visited individual auxiliaries in the State to encourage members to either donate or raise funds for AMEF. Auxiliaries have given luncheons, had fashion shows and teas, rummage sales, bridge parties and many other activities to promote AMEF. Our goal is $5.00 per member and we hope to achieve that in the future.

Members of the auxiliary have cooperated with committees in Civil Defense and Safety. The auxiliaries' specific project has been SWAT for 1961 . . . Safe Water Activity Training.

We have an active committee on Mental Health and are pleased that you have asked one of our representatives to attend your Council's meeting on Mental Health.

We have participated in the TB Speaking Project for nineteen years. Our 1961 program was most gratifying and of the six top winners of high school students, four were young men. Our auxiliaries have invited these students to give their winning papers at their meetings which has greatly increased the interest in this worthwhile project.

I have just given you the highlights of our auxiliary year . . . our Committees work on publicity, contribute to the National BULLETIN of the AMA auxiliary, procure health programs for other organizations such as PTA, Rural Health groups and countless other organizations. Our Community Service chairman listed 150 organizations that our auxiliaries work with throughout the State.

Your auxiliary exchanges visits with the auxiliaries of Illinois Indiana, Ohio, Wisconsin, and Toronto. This vear, as in other years, the state president has visited all of these states together with another officer, with the exception of Wisconsin where only the president attended. It is our opinion that having two officers visit out of state is beneficial for the incoming officers to become informed with what other states are doing and exchanging ideas that keep the auxiliary progressive.

We have divided into nine districts and therefore have nine district directors. We have tried to have each district director be responsible for one meeting a year in her locality to keep the members informed of what is going on. It would be ideal to have more members participate at the annual convention in the fall but that is not always possible due to baby sitting problems, traveling, et cetera.

The district meeting brings the state officers to the meetings and therefore that personal contact which is so important in all phases of activities.

We take time out for hobbies too. This will be the first time that Michigan hopes to have an art exhibit at the fall convention. Arrangements have been made between our Chairman of this new project and Mr. Bill Burns of our office in East Lansing and we are inviting you to participate in what may be a most interesting development by asking you to bring your works of art, et cetera, to Grand Rapids to be on display for all of us to see. Mrs. Robert Emerick of Fremont is our chairman of this art exhibit.

This report is brief . . . its touches just the barest outline of what your Auxiliary is doing and we thank you for the privilege of being your wives.

Public Relations

Public Relations activity has been intimately involved with major projects of the Society as in the past. In addition, the varied subjects involved are indicated by the following activities of the past year. It can be proudly noted that MSMS has effectively assumed leadership in coordinating the work of health, professional, and vocational associations so that an integrated program second to none in the nation has been activated.

—Nomination of Edwin L. Thirlby, M.D., for the AMA General Practitioner of the Year Award.
—Work with science writers and other newspaper representatives.
—Assistance to the Medical Assistants.
—Work with county medical societies, their Auxiliaries and their local medical assistants groups.
—MSMS exhibit at the Michigan State Fair.
—Planning and implementation of complete publicity programs in connection with the Annual Session and the Michigan Clinical In-

stitute, including TV, radio and newspaper, plus special presentations before service clubs, women's clubs, et cetera.

—Special TV programs on such subjects as medical care of the aged, the role of the family doctor, et cetera.

—Directional and cooperative services in connection with the Michigan Health Council State Health Conference, including the 13th Annual Michigan Rural Health Conference, the 3rd Annual Michigan Health Careers State Conference and the 1st Michigan Conference of the Joint Council to Improve the Health Care of the Aged.

—Special Meeting of the House of Delegates held for the purpose of discussing implications of HR 4222 which resulted in four regional meetings throughout the State to inform the doctors on this legislation. (Attendance at three of these regional meetings was disappointing.)

—Similar services were rendered in connection with the Congress of the Professions of which the MSMS Legal Counsel, Lester P. Dodd, was General Chairman, held in Detroit, February 22-23-24.

—Meetings on Public Relations on the state and national level—participated in both by attendance and as program participants.

—As instructed, developed recognition programs for outstanding services of members, science writers, ancillary personnel and a multitude of others by letter, scrolls, gifts, et cetera.

—Preparing, reviewing, and revising films and purchase of prints.

—Testifying before legislative committees and arranging for testimony.

—Active liaison with the Michigan Health Council in its day-to-day operations.

—Recruiting of medical students and medical associates via the preparation of brochures, and the holding of conferences at educational institutions and elsewhere, such as in connection with MAP Career Conferences in Saginaw and the MAP Conference with School Guidance Councilors at Alma College.

—Preparing contacts with Congressmen, Public Health Officers, public officials, and friends of medicine, both in Michigan and Washington, D. C., as well as testimony before Congressional and Legislative Committees.

—Arranging for special information to be given to members of The Council and other key persons on subjects of legislative interest.

—Assistance to county medical societies in programs, the awarding of honors, publicity, and any number of miscellaneous problems.

—Development of brochures for special purposes and articles for THE JOURNAL, MSMS.

—Maintenance of a Public Relations Library and distribution of thousands of publications.

—The taping and telecasting of a weekly series of TV shows over WJBK-TV Detroit and other channels on various medical and health subjects in cooperation with MAP and the Michigan Health Council.

—Rendered planning and promotional assistance in connection with the Presidents Program.

Legislation

Legislative activity during late 1960 and the first three quarters of 1961 has been compounded of almost equal parts of first, intensified activity in support of Kerr-Mills and against King-Anderson federal legislation, and second, the most hectic and arduous state legislative session in memory.

Federal

In anticipation of a concerted drive to bring medical care for the aged under the Social Security system by establishing the "service principle," a full-scale program is being organized to mobilize Michigan physicians in the fight against the King-Anderson Bill and Forand type legislation generally.

An MSMS delegation consisting of Kenneth H. Johnson, M.D., James R. Dehlin, M.D., Lawrence A. Drolett, M.D. Robert J. Mason, M.D., C. Allen Payne, M.D., Hugh W. Brenneman, Public Relations Counsel and M. A. Riley, Public Relations Field Secretary was also dispatched to Washington, D. C., in early May and discussed the federal socialized medicine proposal with all members of the Michigan delegation. Further, MSMS President-elect Otto K. Engelke, M.D., appeared before the Committee on Ways and Means of the United States House of Representatives in July, in opposition to the King-Anderson Bill.

State

In the State capitol the Michigan Legislature considered nearly 1,100 bills and 240 resolutions, one in twenty of which had direct medical implications. Over 80 per cent of these either died in committee or, having passed one House, died in the other. The 71st Legislature was preoccupied with taxation, appropriations, and the imminent Constitutional Convention—first in 53 years.

Legislative Reports from MSMS reflected repeated attempts by chiropractors to expand privilege and practice. House Bill 384, which would have broadened the definition of chiropractic, passed the House but died in the Senate. Senate Bill 1127, designed to license physical therapists, was preempted by chiropractic partisans by an amendment attempting to legalize all its "present practices," thus killing this bill in the House. Finally, an eleventh-hour amendment was placed on Senate Bill 1039, the Medical Aid to the Aged Bill, to make chiropractic services "medical aid" —sending the bill to two conferences between House and Senate before legislators removed the amendment and passed the bill as endorsed by MSMS.

In other areas, a bill was amended which, if

passed, would have required every physician to obtain a second "dangerous drug license" from the State Board of Pharmacy.

The Public Health appropriation was amended to permit payment of physicians' bills rendered in excess of 30 days during fiscal year 1960-61, for services to crippled and afflicted children. While the ceilings on payment to physicians under these acts, unchanged since 1948, were not raised, encouraging progress was made toward general legislative acceptance of the need to raise them in the 1962 session.

Two bills, one to establish minimal standards for ambulances and another to improve the law for testing intoxicated drivers, failed of passage although the latter passed the state Senate.

Despite appearances by ophthalmologists before both House and Senate committees and later before the Governor requesting his veto, House Bill 574 became law and confirmed the present practice of contact lense fitting as part of the definition of optometry.

Attempts to loosen the Psychologists Registration Act of 1959 met defeat in the Legislature, and new licensure laws for hospitals and for dispensing opticians died in the first committee. A bill aimed at control of cancer quackery, House Bill 44, was deferred pending further study of similar legislation in three other states.

Three resolutions of particular interest were passed creating special study committees—one of the Blue Plans, one of the optical sciences, and one of the Crippled and Afflicted Children Acts.

Matters Referred for Action by the 1960 House of Delegates

1. Resolution 1. The Medical Care Study Committee was appointed with H. F. Falls, M.D., Ann Arbor, as Chairman and, as previously reported, recommended that an economist be included in the protective armamentarium of the State Society (see page 1048).

2. Resolution 5 re loan fund for new physicians. The Committee appointed to study this matter, headed by Wm. M. LeFevre, M.D., Muskegon, found (a) that the Michigan Foundation for Medical and Health Education, Inc., could not handle this additional loan area and, (b) the Michigan State Medical Society was not, especially this year, prepared to establish a loan fund from current revenues.

The Committee agreed to study the matter from two approaches: (1) expansion of existing programs to include new physicians, and (2) establishing an MSMS loan fund for this specific purpose. (The new AMA Loan Program for those in need may make the State program unnecessary.)

3. Resolution 6 re hospital emergency care was referred to a special committee of The Council headed by W. L. Brosius, M.D., Detroit. The Committee reviewed a report of the Wayne County Medical Society Physician-Hospital Committee which contains important and interesting information on the emergency care situation in Wayne County, as follows:*

(a) That the rate of utilization of these services is not too high and less than anticipated by Blue Cross when it expanded its out-patient hospital service in 1957. Prior to this time these services averaged 1 per cent of total income with average costs of $7.00 per case. In 1959 it was 2 per cent of total income and $8.56 per case.

(b) The hospitals operate emergency rooms as a service to the public and to the profession. To the hospital this community service is a financial burden.

(c) That although the cost to the patient who has Blue Cross (approximately six out of ten) for care in the hospital emergency room is less, the overall costs to the community are higher.

(d) That the highest quality of care can be provided by the family physician at his office. This is particularly true in medical emergencies which require history, diagnosis, and evaluation before medication is initiated. This committee stated in addition that in its opinion the responsibility and control for the hospital emergency room lies within the medical staff of each hospital. To avoid any misunderstanding, the committee recommended that hospitals make a reasonable effort to notify the family physician on admission of his patient to the emergency room and in all cases to send him a report about the treatment given.

The members of the Committee felt that there are similar problems throughout the State and recommended an MSMS-sponsored statewide survey of hospital emergency care by means of a questionnaire to all chiefs of staff of accredited hospitals in Michigan. This proposal was approved by The Council.

A communication from the Chairman of the Medical Advisory Committee to Michigan Hospital Service (Wm. S. Reveno, M.D., of Detroit) furnished this additional information:

"The Medical Advisory Committee of Michigan Hospital Service has in past years been confronted with several complaints dealing with alleged encroachment on private practice. Two of these have dealt specifically with the problem of physical therapy and several, notably one from a hospital in Flint, have been concerned with hospital emergency room care. In the latter instance the problem relates to the reimbursement of hospital for emergency room services which, in teaching hospitals maintaing intern and residency programs, includes the services of the intern and resident as a part of the hospital out-patient reimbursable expense. This available emergency service has allegedly resulted in many non-emergency cases going to the hospital emergency room for care that

*Published in the *Detroit Medical News*, May 16, 1960.

should properly be rendered in the doctor's office. To clarify the problem it is noteworthy that Michigan Hospital Service reimburses the hospital for the useage of its out-patient facilities and not for doctors' professional services. By policy, the cost of intern and resident training programs are included as part of Michigan Hospital Service reimbursable costs. Such training programs are operated at individual hospitals under the direction and professional supervision of the medical staff of the hospital. Michigan Hospital Service does not undertake to invade the province of the individual hospital medical staff or administrator to establish and control policy governing emergency room practices. It cannot undertake the emergency room policing of case intake and it should not be placed in the position of penalizing the hospital and its subscribers or the medical profession by depriving them of the beneficial aspects of ambulant nonprofessional services provided through hospitals. This conclusion was reached at a meeting of the Medical Advisory Committee on March 16, 1960.

"When Michigan Hospital Service undertook to reimburse hospitals for emergency room services it did so primarily to reduce hospital bed occupancy for minor situations. The matter of determining the eligibility of patients for this service was obviously left to be worked out by the individual hospital and its medical staff. So far, few hospital medical staffs have undertaken a thorough study of the problem and specific plans for screening admissions are practically non-existent.

"Why have the public demands on the hospital emergency room burgeoned? While it is likely that some may choose the hospital to save costs or because they believe insurance provides the service, the great majority seek aid because doctors are not available and their offices are not open twenty-four hours a day. When one undertakes to screen these patients it becomes necessary to define what is meant by emergency. The layman's idea of what constitutes an emergency is often far different from that of the physician and his decision to seek help starts generally at some weird hour during the night. Right or wrong he will seek aid for what he believes is an emergency and he cannot be denied that privilege, even though cooler judgment the next day dictates that no emergency existed. This, as you will recognize, is an exceedingly tricky problem and too rigid a set of rules can seriously damage the standing of hospital and doctor in the community.

"Thus it would seem that while Michigan Hospital Service has helped to make it easier to obtain emergency medical service by reimbursement to the hospital for established facilities such as physical plant and resident house staff, this constitutes only a small portion of the problem. Equally important are the demands of the layman, justifiable or not, and the availability of the practicing physician. The trend toward increased hospital emergency room clinic practice is therefore not being fostered by pre-payment plans alone. In order that such emergency care shall be rendered within the framework of the private practice of medicine it had best be supervised by the individual hospital medical staff and more pointedly by the individual practicing physician. The recommendation that Michigan Hospital Service discontinue the practice of "paying for routine clinic care" in hospital emergency rooms would not solve the problem since the public would continue as before to seek medical aid wherever it was available. Hospitals would continue to be stormed by the demands for services and would be compelled to render such services whether special departments were provided or not."

4. Resolution 7 re repeal of basic science law and enactment of a uniform healing arts act was referred to the Legal Affairs Committee which appointed a subcommittee to review the entire matter. An interim report of the subcommittee was presented to the Legal Affairs Committee on June 13 which included the results of a preliminary exploration of the subject with the deans of the two medical schools in Michigan and with the Judicial Council of the AMA. The Committee requested the subcommittee to continue its study of implementing Resolution No. 7 of 1960.

5. Resolution 9 re nurses training program: the action of the 1960 House of Delegates was directed to the various organizations in interest, as directed.

6. Resolution 16 re transfer of membership. The AMA recommended a solution might be reached on a regional basis, so correspondence was initiated with all the states in the Great Lakes region (Ohio, Indiana, Illinois, Wisconsin), all of whom expressed interest in the problem except Ohio. A meeting of representatives of the Great Lakes states was scheduled for New York, during the AMA Session, but in the meantime the introducer of the resolution (C. I. Owen, M.D., Detroit) asked that the matter be dropped. Further consultation on the subject among the Great Lakes states, through correspondence, is anticipated.

7. Resolution 17 re appointment of MSMS Historian. The Council was honored to receive acceptance from Wm. J. Stapleton, Jr., M.D., of Detroit as Historian.

8. Resolution 24 re employee recognition. The Council decided the appropriate time for this recognition was during the Christmas Holidays.

9. Resolution 25 re Presidents Program (this was previously reported—see item e, page 1045).

10. Resolution 39 re visual screening program was referred to the MSMS Child Welfare Committee which is implementing the directive of the 1960 House of Delegates.

11. Resolution 40 re insurance report forms. This information was disseminated through the MSMS Secretary's Letter.

12. Resolution 52 re adjustment of Michigan

Crippled Children Commission Fee Schedule. This was referred to the Legal Affairs Committee which reports elsewhere that encouraging progress was made in the 1961 Legislature toward revising the existing medical fee ceilings in the Crippled and Afflicted Children Acts (now, no more than $90 for any procedure or $200 for any one patient in any one year). The Committee feels that the ceilings, unchanged since 1948, may be raised to more realistic levels during the 1962 session. It is to be noted that the appropriation bill covering crippled and afflicted children services was amended to permit payment of physicians' bills for services rendered during the period July 1, 1960 to June 30, 1961 to said children when bills were rendered beyond 30 days after discharge of the patient; in other words, these tardy billings will now be paid by the State. In addition, legislative sentiment was developed in the 1961 session for increasing the maximum billing period under the Crippled and Afflicted Children Acts from 30 to 45 days.

Recommendation No. 7 on the subject of Uniform Fee Schedule for Governmental Welfare Agencies follows.

13. Resolution 53 re residency training programs: after a thorough discussion with the Secretary of the AMA Council on Medical Education and Hospitals, the introducer of this resolution (J. L. Livesay, M.D., of Flint) asked that this resolution be withdrawn as "no area of disagreement exists."

14. Resolution 54 re revised rules and order of business of the House of Delegates. This has been implemented by Speaker Lightbody and all information will be presented to Delegates in folders with the material on 8½"x11" printed or mimeographed sheets.

15. *Matters Referred to Michigan Medical Service*—All resolutions re the operation of Michigan Medical Service were referred to that Corporation on November 14, 1960 (resolutions No. 19, 41, 47, as well as the instruction that MMS revert to its original participating agreement). The Michigan State Medical Society turned over all material and records in connection with the MSMS Seal of Assurance Plan and M-75 participation agreements on December 5, 1960 and notified the MSMS membership through the Secretary's Letter that Michigan Medical Service is now handling all MMS participating agreements; and further that Michigan Medical Service will submit mediation matters to the component societies for referral to their own mediation or other appropriate committee. MMS reported its follow through on House of Delegates actions in a letter to The Council dated December 16, 1960.

An up-to-date report will be presented to the House of Delegates by Michigan Medical Service on September 25-26.

16. *Dedication of a Number of* THE JOURNAL *to Wilfrid Haughey, M.D.*—This was accomplished in the February, 1961 Number.

17. *Prevention of Highway Accidents.*—The Council wrote all auto manufacturers urging them to increase the use of safety factors in their products. Very fine and thoughtful explanatory replies were received from the auto officials, indicating their efforts in accident prevention and safety. MSMS expressed its great interest and offered cooperation which was accepted by the automobile manufacturers.

18. *Washington, D. C. Trip.*—As instructed by the House of Delegates, your representatives visited Michigan Legislators in Washington, D. C., April 30-May 3. This visit emphasized the continued need for a grass roots informational campaign and further that the startling change in concept of Social Security from indemnification to service, strongly invited to the Congressmen's attention, must be stressed to all MSMS members and to the public.

Recommendation No. 8 on this subject follows.

Recommendations

1. That The Council be authorized to arrange Councilor Conferences, prior to the Annual Session, to continue communication and share information with delegates, alternate delegates, and component society officers, as during the past four years.

2. That the House of Delegates approve the holding of an annual "General Meeting" of the State Society as part of the last meeting of the House of Delegates.

3. That the House of Delegates place on its record a high vote of commendation to the personnel of the Relative Value Scale Study Committee for three years' arduous labor in producing this scale in concert with all Sections and specialty groups of medicine in this State concerned with this important socio-economic matter.

4. That component societies stimulate congratulatory communications to magazine editors who present to their readers true facts on what Medicine is attempting to do for the benefit of the peoples' health; and conversely that they encourage letters of protest against unfavorable or slanted and untrue articles about Medicine that are published mainly to engender nation-wide controversy to increase sales for that particular issue of the magazine and not primarly for the public's good.

5. That the House of Delegates give serious consideration to the pressing need for the retaining by the Michigan State Medical Society of either a staff economist and/or the services of special consultant economists to evaluate socio-economic studies affecting medical practice, and that it instruct The Council in the procedure to be inaugurated including the financing of this new department activity.

6. That the House of Delegates encourage component societies and individual members to "accentuate the positive" in reminding the public that Medicine in the United States is the BEST

in the world and that any attempts to dilute its quality, through socialization, will mean less service to and poorer care for the people; and that the Kerr-Mills medical care for the aged program is working and working well for the people who need this program.

Further, that the House of Delegates request county societies to continue and to intensify their action program against political medicine for the aged; and that every MSMS member be urged to know and recognize the intense seriousness of the present threat to private medical practice and best medical care, and that they personally inform patients and other friends of this overt campaign for general socialism.

7. That component societies continue their work to revise their fee schedules for medical care of indigents so they are in line with the Uniform Fee Schedule for Governmental Welfare Agencies.

8. That The Council be authorized to send MSMS representatives to Washington, D. C.. in 1962 on the occasion of the annual Michigan Day, as recommended for many years by the House of Delegates.

9. That the House of Delegates encourage component societies to discuss, at least every other year, the subject of malpractice as part of a necessary campaign of prevention; component societies will find their Councilor or the Chairman of the MSMS Committee on Malpractice qualified to speak on this subject.

H. J. Meier, M.D., *Chairman*
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John J. Coury, M.D.
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William Bromme, M.D.
I. J. Lightbody, M.D.
H. F. Falls, M.D.
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D. Bruce Wiley, M.D., *Secretary*
W. A. Hyland, M.D., *Treasurer*
M. A. Darling, M.D., *Immediate Past President*

ANNUAL REPORT OF COMMITTEE ON BLOOD BANKS—1960-1961

There were no formal meetings of the Committee on Blood Banks during the year. There was, however, a scientific meeting held for one day by the Michigan Association of Blood Banks, which is co-sponsored by the Michigan State Medical Society and the Michigan Pathological Society. This meeting was held in November, 1960. Two workshops on blood banking techniques were presented during the year. All of these activities are aimed at improving the blood bank services in the state of Michigan.

R. L. Mainwaring, M.D., *Chairman*
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D. L. Kessler, M.D.
R. E. Lininger, M.D.
E. E. Muirhead, M.D.
L. W. Walker, M.D.

ANNUAL REPORT OF COMMITTEE ON DIABETES—1960-1961

Your committee's activity mainly consisted of cooperation with the Michigan Diabetes Association in the campaign of diabetic detection.

Much emphasis was placed on the doctor's office as the most effective method of detection. Routine urinalysis on all patients and blood tests on those who have suspicious symptoms are expected of all physicians.

The committee also again advised county medical societies to include talks on the diagnosis and treatment of diabetes in their scientific meetings. The Postgraduate Medical Education Committee is again asked to include diabetes in their program. All county societies are to be informed of the Michigan Diabetes Association's Speakers Bureau and are urged to request speakers whenever possible.

Further efforts are to be made to get papers on diabetes included in the MCI and annual session programs of the state society. The matter of the increase in fetal mortality in pregnancies in diabetic women is to be referred to the Maternal Health Committee with the hope that that committee can help in obtaining a greater degree of diabetic control during pregnancy in order to reduce this rate.

William M. LeFevre, M.D. *Chairman*
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J. A. Cowan, M.D.
P. J. Moore, M.D.
J. B. Rowe, M.D.
Bert Van Ark, M.D.
K. K. Vining, Jr., M.D.
H. L. Woodburne, M.D.

ANNUAL REPORT OF CANCER CONTROL COMMITTEE—1960-1961

The Cancer Control Committee of the Michigan State Medical Society held one meeting mainly for the purpose of reviewing the revised Bylaws of the Michigan Cancer Registry as recommended by the Michigan Cancer Coordinating Committee (at its January 12, 1961, meeting). The Cancer Control Committee approved the amended Bylaws of the Michigan Cancer Registry and recommended that The Council of the Michigan State Medical Society also approve same (which The Council did).

Scientific articles on cancer to appear in The Journal of the Michigan State Medical Society were allocated, on a bi-monthly basis, to various members of the Cancer Control Committee.

The Committee considered the lack of uniformity in reporting positive and negative smears and the need for informing physicians how to handle reports; it was felt that a uniform method of reporting should be developed on a national basis; the Committee authorized its Chairman to convey this information and suggestion to the Committee on Cytology of the American Cancer Society.

H. M. Nelson, M.D., *Chairman*
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J. A. Cowan, M.D.
L. E. Holly, M.D.
J. W. Hubly, M.D.
W. A. Hyland, M.D.
C. Allen Payne, M.D.
H. M. Pollard, M.D.
Ralph Ten Have, M.D.
H. J. VandenBerg, Jr., M.D.

ANNUAL REPORT OF MEDICAL CARE STUDY COMMITTEE—1960-1961

There have been three meetings of this Committee since its establishment: May 3, 1961, May 24, 1961, and June 18, 1961.

The specific recommendations of this Committee have been submitted to the House of Delegates in a more detailed report. They include in particular:

(1) Establishment of a standing MSMS Committee on Medical, Social, and Economic Trends.

(2) Establishment of a MSMS Department of Socio-Economics.

(3) Employment by MSMS of an Economist.

(4) That this Economist be located in the Detroit area near major research facilities.

(5) MSMS provide $30,000-$35,000 per year for establishment, implementation of functions, employees, etc., of this Department of Socio-Economics.

(6) Establishment of Socio-Economic committees by all component County Medical Societies and other medical organizations.

(7) Urge House of Delegates Reference Committee on Ways & Means to recommend financing this program.

(8) Urge retaining services of consultants, on per-diem basis, of established independent economists to advise on emergency, particular questions or problems.

H. F. Falls, M.D., *Chairman*
D. L. Kessler, M.D.
L. R. Leader, M.D.
O. B. McGillicuddy, M.D.
J. W. Rice, M.D.
G. W. Slagle, M.D.
D. N. Sweeny, Jr., M.D.

ANNUAL REPORT OF THE PUBLIC RELATIONS COMMITTEE—1960-1961

During the year just past, this Committee has strived to increase its production. The result has been fewer projects but greater extension of service to establish communication media and through ancillary, auxiliary and related vocational and professional organizations.

In addition to the work noted in the report of The Council, and supplementing the work of many scientific and socio-economic committees, we have carried out a program designed to so inform and persuade the public that it will continue to have confidence in the practicing doctor of medicine, his organizations and his philosophies.

Television and Radio: Additional "family doctor" television shows to those of last year were presented supplemented by appearances over established programs or on specially allocated periods. Cooperation was given to the Michigan Association of the Professions—Michigan Health Council TV program "Decision—The Moment of Truth," a program built to explain why professional people do-what-they-do-in-the-way-that-they-do-it and how to make best use of professional people. Several radio programs were originated by MSMS and participation by M.D.'s in these programs were outstanding. Continued support was given the U. of M. health series broadcast in tape over local radio stations.

Intra-Professional Liaison: Visits to county medical societies, the Upper Peninsula Medical Society and sundry specialty groups maintained intra-professional liaison. All requests for services by county medical societies or individual members were gladly received and carried out.

Motion Pictures: The documentary film on the new MSMS Headquarters was completed. This film will be used as part of the President's Program, and to acquaint the membership and the public with the new building and the expanded services of MSMS. Several films prepared by the AMA and other recognizably authoritative organizations were purchased and/or distributed.

Michigan Association of the Professions: This organization has grown to a membership of 3,616 and has effectuated a brilliant program of service in the fields of: 1. Education, 2. Public Relations, 3. Legislation, and 4. Business Services. Of particular advantage to the medical profession were:

(a) The Congress of the Professions—Detroit, February 22-23-24, which held hearings on the subjects noted above and presented among other outstanding speakers, Thomas A. Francis, Jr., M.D., Department of Epidemiology, School of Public Health, University of Michigan, Ernest B. Howard, M.D., Assistant General Manager of the American Medical Association, The Honorable John W. Byrnes, United States Congressman of Wisconsin, and Charles R. Sligh, Jr., Executive Vice President of the National Association of Manufacturers.

(b) Day-long meetings to recruit students such as that held at Saginaw, where students from a large area were interviewed by 7 deans of graduate schools, among them Dean Gordon H. Scott, Ph.D., College of Medicine, Wayne State University. Another conference with guidance counselors was held at Alma College with such men in at-

tendance as Lyman Smith, Director of AMA Scholarship program, Nicholas Mizeres, M.D., College of Medicine, Wayne State University and representatives of several professions as well as the guidance counselors.

(c) Legislative support of the Keogh Bill and opposition to the Forand Bill by letter.

(d) The implementation of Group Term Life, Major Medical Insurance and disability insurance programs, plus other business services such as the "new office" furnishing and equipping program.

"Decision—The Momenth of Truth." The taping and telecasting of a weekly series of TV shows over WJBK-TV Detroit and other channels (soon to be seen over Channel 56 Detroit and Channel 10 Lansing) on various medical and health subjects in cooperation with MAP and the Michigan Health Council. Many doctors cooperated on this series of programs.

Pamphlets: Distribution of AMA pamphlets was emphasized this year in view of the excellence of these publications. Schools, school libraries, doctors' offices, etc., served as outlets for these. In addition, the MSMS "Emergency Medical Card" and the pamphlet "Your Family Health Record" were distributed in the number of several thousand and a special display poster-pamphlet and insert-card was prepared.

Public Relations Conference: The County Secretaries-Public Relations Seminar was held in January. An excellent attendance complemented an outstanding roster of speakers.

Mass Media: By means of press releases to all Michigan newspapers, radio and TV stations, reports of current work of MSMS was carried to the general public. Also special stories were released to home-town papers of Doctors who received special honors. The work of the staff with the newspapers is a never-ending task highlighted by special work under the direction of the Press Committee at the Annual Session and the M.C.I.

Speakers Program: For the fifteenth consecutive year, a group of M.D. speakers appeared before service clubs of Detroit and Grand Rapids in connection with Annual Session and M.C.I. weeks. Throughout the year, the medical profession served the schools, colleges, clubs, ancillary groups and business organizations with a steady flow of speakers on an unusually broad variety of subjects—uppermost this year, were talks on the problems of the aged, including the Michigan White House Conference on Aging and the National White House Conference on Aging.

Publications: Many legislative and other special bulletins were issued during the past year. Aid was given The Auxilium, meeting announcements and JMSMS articles. The new publication, *Medical Economic Currents*, was published containing capsulated and charted facts of major interest. This was sent to 1,000 MSMS members who have state and county responsibilities which place them in the position of developing policy and expressing medicine's position to the public. This publication also provided opportunity for the reprinting of these charts in county society bulletins. The new Medical Career Guide was prepared by MSMS and published by the Michigan Employment Security Commission. The special sub-committee in charge of this project was headed by J. M. Sheldon, M.D. In addition, a revision and reprinting of "Planning Your Career," the publication about medical associates' careers was accomplished.

PR Library: This growing repository of working materials continues to increase in value and usage. Adequate accommodations have been made available and it is anticipated that next year will see a vastly increased service emanating from this valuable facility.

Civic Affairs: Increased interest in civic affairs has been evidenced by county societies during the past year. Delegations of doctors to Lansing and Washington, D. C., participating in Aging Conferences, Regional Health Conferences, political parties, local "Homearamas," etc., have indicated an increasing interest by the profession in civic duty.

Michigan Health Council: Directional and cooperative services in connection with the Michigan Health Council, including the 13th Annual Michigan Rural Health Conference, the 3rd Annual Michigan Health Careers State Conference and the 1st Michigan Conference of the Joint Council to Improve the Health Care of the Aged, and the Michigan Health Council State Health Conference was held in Flint, May 23-24. This proved to be one of the finest medical conferences of a socio-economic nature in the state this year, but more attendance by doctors of medicine is urged in the future.

President's Program: The President's Program, to be reviewed elsewhere, is getting under way and vast possibilities for outstanding public relations gains are inherent in it.

Comment: Try as the profession will, the concerted efforts of its powerful enemies (enemies not of scientific medicine but of the profession's concept of the best way to practice medicine) are making inroads in public thinking. This Committee feels duty-bound to urge increased activity (and financial support) in the future, both on the part of the individual doctor and of organized medicine.

R. W. Teed, M.D., *Chairman*
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J. W. Bunting, M.D.
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W. J. Dinnen, Jr., M.D.
G. A. Drake, M.D.
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G. E. Millard, M.D.
W. Z. Rundles, Sr., M.D.
S. R. Russell, M.D.
Sydney Scher, M.D.
E. W. Schnoor, M.D.
J. M. Sheldon, M.D.
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W. F. Strong, M.D.
C. K. Stroup, M.D.
C. L. Weston, M.D.
J. M. Wood, M.D.
B. T. Montgomery, M.D., *Advisor*
E. S. Oldham, M.D., *Advisor*
A. E. Schiller, M.D., *Advisor*
T. P. Wickliffe, M.D., *Advisor*

ANNUAL REPORT OF COMMITTEE TO STUDY PROBLEM OF MALPRACTICE 1960-1961

No matters were referred to the House of Delegates Committee to Study Problem of Malpractice during the 1960-1961 Society year and, therefore, no meetings were scheduled. However, this Committee wishes to reiterate the statement urging component medical societies to have regular meetings to discuss the problem of malpractice and the avoidance of malpractice suits.

Material for such discussions and/or talks is available to the component medical societies at the office of the Committee Chairman, William M. LeFevre, M.D., 315 Clay Avenue, Muskegon, Michigan.

The Chairman and members respectfully recommend to the House of Delegates that this Committee be retained during 1961-1962.

William M. LeFevre, M.D., *Chairman*
E. W. Hall, M.D.
F. B. MacMillan, M.D.
Wm. J. Stapleton, M.D.
A. J. Vorwald, M.D.
F. G. Buesser, LL.B., *Ex Officio*
Lester P. Dodd, LL.B., *Ex Officio*

ANNUAL REPORT OF COMMITTEE TO REVIEW CONSTITUTION AND BYLAWS 1960-1961

The Committee met on May 21 and twice subsequently during the year and concluded a complete examination of the Constitution and Bylaws item by item.

Our report will reach the Delegates well before the Annual Session in the form of a copy of the new and the old Constitution and Bylaws in order that a complete examination may be conducted.

In accordance with the recommendation of the 1960 Committee, the present work constitutes a complete revision with such corrective changes in language as were deemed necessary and a shifting of chapters or sections has been done in order to consolidate items bearing on the same subject.

The result is a more pleasing and easily usable document which will be completely indexed for quick reference. The unusual detail and effort involved is the work of our Legal Counsel, Lester P. Dodd, whose tremendous contribution is gratefully acknowledged.

L. J. Bailey, M.D., *Chairman*
R. R. Cooper, M.D.
A. B. Gwinn, M.D.
H. J. Meier, M.D.
F. P. Rhoades, M.D.
J. A. Witter, M.D.
L. P. Dodd, LL.B., *Advisor*

ANNUAL REPORT OF MEDIATION COMMITTEE—1960-1961

No matters were brought to the attention of this Committee during the past year, so it was unnecessary to call the Committee into session.

L. R. Leader, M.D., *Chairman*
D. R. Boyd, M.D.
E. B. Johnson, M.D.
R. P. Lytle, M.D.
G. B. Saltonstall, M.D.
E. F. Sladek, M.D.
R. W. Teed, M.D.

ANNUAL REPORT OF THE LEGAL AFFAIRS COMMITTEE, 1960-1961

The Michigan Legislature spent seventy-eight days in actual session during 1961 and considered nearly 1,100 proposed laws and over 240 resolutions. Close to one hundred of these had direct medical implications.

The session was particularly marked by the persistent and repeated efforts of the chiropractic group to expand their privilege and practice. In general, veteran observers are unanimously agreed that the entire 1961 session was the most hectic and arduous in memory.

During the session eight "Legislative Reports" were mailed to CMS officers, three of which went to all MSMS members.

As the session progressed the Legal Affairs Committee considered proposed legislation concerning: mechanical procedures regarding eligibility under the Crippled and Afflicted Children Acts, county health department regulations, various health appropriation measures, workmen's and unemployment compensation amendments, a suggested Health Advisory Board, amendments to the Dental Practice Act and the proposed establishment of a State Scholarship Committee.

The Legal Affairs Committee also reviewed all

proposed appointments by the Governor to health-connected State boards, agencies and commissions, and embarked on a study of the implications of Single Medical Practice Act legislation. Exploration of the possibility of repeal of the Basic Science Act with all interested agencies and involved parties led to the committee conclusion that it would be unwise to proceed in this direction at this time. The committee recognizes the possibility that some recommendation regarding a single licensing agency might eminate from the 1961 Constitutional Convention, in which case the matter would go before the people for acceptance or rejection.

The final status of specific key legislation during this session follows:

Medical Aid to the Aged—Passed, without recognizing chiropractic services as medical services; liberalized by permitting income of married couples up to $2,500 (formerly was $2,000), and adding home nursing care and up to 90 days in any one year of nursing home care following hospitalization for acute illness.

Chiropractic Licensure—bill to permit treatment by chiropractors of "any human ailment or disease" was defeated.

Physical Therapists—bill to license defeated; contained amendment to legalize all "present practices" of chiropractors.

Hospital Licensure—this proposal did not pass.

Dispensing Opticians—a proposal for a new licensure law did not pass.

Optometrists—a bill confirming the present practice of contact lens fitting as a part of the practice of optometry passed, although opposed by Michigan Ophthalmologists.

Cancer Quackery—a proposal to control did not pass, pending study of newly enacted similar legislation in three other states.

Drugs—a proposal that all prescriptions be written on forms provided by the State Board of Pharmacy did not pass; a proposal which would have required all physicians to obtain a special dangerous drug license from the State Board of Pharmacy to handle certain drugs did not pass.

Crippled and Afflicted Children Acts—appropriation bill amended to permit payment of physicians' bills for services rendered, during the period July 1, 1960, to June 30, 1961, to crippled and afflicted children when such bills were rendered in excess of 30 days after discharge of the patient.

Psychologists—proposal to reduce basic requirements for licensure did not pass.

Drunk Driver Testing—proposal to improve the law passed in 1960 did not pass both houses, but did pass State Senate.

Ambulances—proposal to provide minimum standards for ambulance operation did not pass.

Legislative sentiment was developed for (1) increasing the maximum billing period under the Crippled and Afflicted Children Acts from 30 days to 45 days and (2) for establishing minimum standards for ambulance operation. Both goals may be reached during the 1962 session.

Encouraging progress has also been made toward raising the existing medical fee ceilings in the Crippled and Afflicted Children Acts (no more than $90 for any one procedure or $200 for any one patient in any one year). These ceilings have been unchanged since 1948, and may be raised to more realistic levels during the 1962 session.

The following Legislative Interim Study Committees were established by the Michigan Legislature: (1) to investigate the Blue Plans, (2) to investigate the optical sciences, and (3) to investigate the Crippled and Afflicted Children Acts.

On the Washington, D. C., scene, the concerted drive to establish the "service principle" of medical care, as opposed to cash benefits, under social security has dominated MSMS interest. MSMS representatives including the Legal Affairs Committee Chairman attended a special medical legislative conference on this subject in Chicago in mid-March and the Chairman reported on this meeting to the special session of the House of Delegates held in East Lansing in mid-April. An MSMS delegation went to Washington, D. C., in early May to discuss pending social security legislation with all Michigan members of Congress.

During this extremely active year for the Committee, its members are deeply grateful for the splendid cooperation of all MSMS members whenever their assistance was requested in calling facts to the attention of State and National lawmakers. It was largely through the instant and effective response of MSMS members that Michigan legislators were well advised on critical proposals in Lansing, and that Michigan members of the Congress have been apprised of the continuing desire of the medical profession to maintain for the United States the finest quality of health care in the world today. The Committee sincerely thanks each and every member.

L. A. Drolett, M.D., *Chairman*
O. B. McGillicuddy, M.D., *Vice Chairman*
A. B. Aldrich, M.D.
J. C. Elliott, M.D.
Otto K. Engelke, M.D.
K. H. Johnson, M.D.
H. J. Meier, M.D.
P. T. Mulligan, M.D.
Mr. John J. Powers
J. S. Rozan, M.D.
A. E. Schiller, M.D.
H. A. Towsley, M.D.
B. C. Wildgen, M.D.
Mr. Lester P. Dodd, *Advisor*

ANNUAL REPORT OF THE CHILD WELFARE COMMITTEE 1960-1961

The Child Welfare Committee held two meetings during the past year, December 8, 1960, and June 14, 1961. Included in their discussions were

reports from the various subcommittees which had also met during the past year.

The Committee received a report that some progress was being made with Adoption Agencies, although proposed revisions in the law did not provide all that would be desired with regard to adoption of children. The Committee was further advised that there were 6,000 adoptions, per year, in Michigan, with slightly over half adopted by stepfathers, about 1,500 being adopted through official agencies and another 1,500 being placed direct by the mother, without legal approval.

The Committee was advised concerning the training and supervision of Audiometric Screening Technicians provided by the Michigan Department of Health. It should be noted that children found with hearing loss are examined by Otologists and referred to their own physicians for treatment. Over 70 per cent have returned to normal, or greatly improved hearing. The Child Welfare Committee has requested an issue of JMSMS in 1962 and propose to develop articles concerning Otolaryngology, Psychiatry, Ophthalmology and other fields involved with child health.

The Subcommittee on Ophthalmology had discussed the need for pre-school examination materials for both sight and hearing, and had met unofficially with representatives of the Michigan Optometric Association.

The Committee participated in the preparation of the "Michigan School Health Record," CA 60-C form, which has been approved by the State Department of Public Instruction and the Michigan Department of Health for use in schools throughout the state. The Committee is currently working on the preparation of a simple form for physicians to use in transmitting to schools, following examination of children in their offices, pertinent information for the CA 60-C record.

The Committee is working with the Michigan Department of Health toward the development of rules and regulations for Pediatric Departments of General Hospitals, to be available if a General Hospital Licensing Law is passed by the Michigan Legislature.

The Committee is much concerned with Youth Fitness Programs and felt a serious need for leadership by members of the medical profession.

A resolution was passed, as follows:

Whereas, the Health of the youth of the nation is of primary importance to national development and security, and

Whereas, the Doctors of Osteopathy are working in some areas in youth fitness and development, and

Whereas, there is available personnel to advise and counsel from the State Health Department, therefore be it

RESOLVED, That the Michigan State Medical Society, as part of the Presidents Program, contact every county medical society regarding the formation of local Youth Fitness Committees and urge these committees to meet with Parent Teacher Associations, Athletic Directors, and Coaches to develop a continuing program of youth fitness on a local level, and be it further

RESOLVED, That to implement this program and a further step in the Presidents Program, this resolution be presented to the House of Delegates of the Michigan State Medical Society in September 1961.

R. H. Trimby, M.D., *Chairman*
J. C. Montgomery, M.D., *Vice Chairman*
R. T. Blackhurst, M.D.
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C. F. Payton, M.D.
M. H. Pike, M.D.
H. A. Towsley, M.D.
A. L. Tuuri, M.D.
E. H. Watson, M.D.

Federal Request

Commissioner of Food and Drugs George P. Larrick has called on the pharmaceutical industry, the medical profession, and retail druggists to intensify their efforts to stamp out abuses in the repacking of physicians' samples.

At the same time, the Commissioner directed Food and Drug Administration inspectors throughout the country to increase their activities in this field.

The action came in the wake of discovery of an additional mix-up in repackaged physicians' samples in the possession of a retail pharmacy in Kansas City, Missouri.

A total of 15 seizures of physicians' sample drugs that were being held for sale has been instituted by FDA in the last two weeks.

The Commissioner recommended four steps including a reduction in the distribution of physicians' samples of drugs to that quantity which may reasonably be used by physicians in their practice.

Technical Exhibitors

(Alphabetic List)

Abbott Laboratories **Booth No. 305**
North Chicago, Ill.

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

A. S. Aloe Company **Booth No. 118**
St. Louis, Mo.

A. S. Aloe Division of Brunswick Corp. proudly exhibits its new 2nd Century Physicians examining room furniture. New concepts in function, construction and advanced materials.
Shown, too, is a group of new items developed for and by doctors to simplify and speed office techniques of diagnosis and treatment.

American Sterilizer Company **Booth Nos. 510-512**
Erie, Pa.

Ames Company, Inc. **Booth No. 106**
Elkhart, Ind.

The many urine diagnostic specialty products of Ames Company will be on display. You are cordially invited to stop at the booth for a demonstration. The application of these tests to office procedure can save you time and money. LET US DEMONSTRATE!
Therapeutic products including DECHOLIN/Belladonna will be presented.

Armour Pharmaceutical Company **Booth No. 206**
Kankakee, Ill.

The Armour Pharmaceutical Company exhibit will feature Chymoral, a new systemic anti-inflammatory enzyme tablet which reduces inflammation, swelling and pain; Chymar Aqueous, the parenteral systemic anti-inflammatory enzyme; and Chymar Ointment, the topical form.

Astra Pharmaceutical Products **Booth No. 314**
Worcester, Mass.

Descriptive literature pertaining to preparations of XYLOCAINE® HYDROCHLORIDE (ASTRA) for infiltration, regional block, peridural, spinal, and topical anesthesia, XYLOCAINE OINTMENT, XYLOCAINE JELLY, and XYLOCAINE VISCOUS for topical application, as well as ASTRAFER® I.V. for iron deficiency states, will be available at the ASTRA booth presided over by Edward W. Friedel.

Audio-Digest Foundation **Booth No. P-11**
Glendale, Calif.

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in six series—General Practice (issued weekly and bi-weekly), and Pediatrics, Internal Medicine, Surgery, Obstetrics and Gynecology, Anesthesiology (all issued semi-monthly). The one-hour long tapes are selected and reviewed by a professional Board of Editors. Digest subscribers listen in their car, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

Baker Laboratories, Inc. **Booth No. 416**
Cleveland, Ohio

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.
Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

Barry Laboratories, Inc. **Booth No. 104**
Detroit, Mich.

YOU—will want the latest information on—
BARTHRO—The non-steroid, non-toxic Enzyme treatment for Arthritis.
MERPHENE—The most effective germicide non-injurious to mucous linings. Will kill antibiotic resistant Staphylococcus aureus in less than 30 seconds and clostridium tetani in less than 5 minutes.
ALLERGY—A growing problem of the medical profession.

Baxter Laboratories, Inc. **Booth No. P-19**
Morton Grove, Ill.

Baxter Laboratories, Inc., cordially invites you to view its latest developments in parenteral fluid therapy.
The Travenol Division features the regional perfusion oxygenator, PERFUSO-PAC™, which serves as a small "heart-lung" for the portion of the body undergoing treatment for certain cancers, and permits administration of huge doses of cancer-fighting drugs previously not used in such quantity because of possible damage to vital organs, and COZYME® for the physiologic correction and prevention of intestinal atony, abdominal distention, retention of flatus and feces and paralytic ileus.

Borcherdt Company **Booth No. 110**
Chicago, Ill.

MALTSUPEX® (Malt Soup Extract), Liquid and Powder. Laxative modifier of milk for constipated babies. Also useful for geriatric constipation and pruritus ani.
UROLITIA®: For chronic urinary tract infections in older patients. Quickly relieves burning urination. Especially useful for use over a long period of time.
FERROMALT® TABLETS: Non-constipating Ferrous Sulfate Tablets. Good clinical response without usual side effects of oral iron. Ferromalt Tablets are inexpensive and well tolerated.
Stop in for recently published papers and samples.

The Borden Company **Booth No. 508**
New York, N. Y.

Extending the "Metha" principle to a wider area of topical dermatological usefulness, *new* Methatar, new new Methaphor and new Methaseptic are being introduced at the Borden exhibit. A concise guide to treatment of skin disorders with "Metha" topicals is available
Also on display are the well established infant nutritionals, Bremil & Mull-Soy.

Bristol Laboratories **Booth No. 215**
New York, N. Y.

Continuing its program of developing antibiotics for almost every antibacterial infection, Bristol Laboratories' exhibit will feature one of its synthetic penicil-

lins. This display will communicate the significant advantages of this Bristol Antibiotic by a visual description of its *in vitro* and *in vivo* activity. Representatives will be available to discuss the details of synthetic penicillins.

Brooks Appliance Company **Booth No. 313**
Chicago, Ill.

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated primer Bandage plus the Dalzoflex Elastic Adhesive Bandage which are used in treating leg ulcers and phlebitis.
As distributors of Anatomical Supports, our representatives will be in attendance to answer questions and explain in detail our Sacral, Sacral-Lumbar and Dorsal-Lumbar supports. Also, the Dr. Hackett "nationally approved" "C" Sacral belt, Flexion and Extension Cervical Collar, Brooks Cervical Traction Outfit, Elastic Stockings, Nulast Elastic Crepe Bandages and Surgical Instruments will also be displayed.

Burroughs Wellcome & Company, Inc. **Booth No. 202**
Tuckahoe, N. Y.

You are cordially invited to visit Burroughs Wellcome & Co. (U.S.A.) Inc., Booth 202, for the latest information on our products, and the newest developments from the extensive research facilities of Burroughs Wellcome & Co.
Of particular interest at this meeting will be our new topical and ophthalmic antibiotic products, as well as our 'Actifed-C' Expectorant. Our informed staff welcomes this opportunity to show you these new products.

Cambridge Instrument Company, Inc. **Booth No. 514**
New York, N. Y.

The Cambridge "Versa-Scribe"—the Versatile Portable Electrocardiograph; and the Cambridge "Simpli-Scribe" Model Direct-Writing Portable Electrocardiograph will be displayed at this booth. Also other important Cambridge instruments, including the Audio-Visual Heart Sound Recorder, Operating Room Cardioscope, Educational Cardioscope, Multi-Channel Physiological Recorder, Electrokymograph, Plethysmograph, pH Meters, and Pulmonary Function Tester. The Cambridge Engineers in attendance will be glad to give you complete information on these instruments.

Cameron Surgical Instruments Co. **Booth No. 203**
Chicago, Ill.

Cameron Surgical Instruments Company will display its new Major Electrosurgical Unit for hospital use, as well as those for modern office surgery. Also showing Suction Coagulation Electrodes, Snares, Biopsy Forceps, electrically illuminated Ano-Procto-Sigmoidoscopic equipment (distal and proximal), Vaginal Speculae, Otoscope, Mouth Gag, Transilluminators, Gastroscopes, Headlites, Binocular Loupes, Luxo Lamps, etc. We would like the opportunity of demonstrating to you.

Carnation Company **Booth No. 116**
Los Angeles, Calif.

Carnation Company cordially invites you to visit Booth No. 116, where Medical Representatives will be pleased to welcome members and guests of the Michigan State Medical Society.
Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat, and Carnalac are available.
Any Question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

Chemico Laboratories, Inc. **Booth No. 213**
Miami, Fla.

Chemico Laboratories, Inc., will exhibit Reticulose, a lipoprotein-nucleic acid complex, produced in an injectable form and reported effective in the therapeutic management of various virus infections, i.e., Herpetic diseases, Infectious Hepatitis, Encephalitis, Vaccinia, Influenza, Infectious Mononucleosis, with clinical improvement objectively and subjectively anticipated in 24 to 36 hours.

Chicago Pharmacal Company **Booth No. 316**
Chicago, Ill.

URISED: Clinically proven tablet for both comfortable sedation and thorough antisepsis in genitourinary affections.
MYOSED: A brand-new styramate skeletal muscle relaxant combined with two well-tolerated analgesics, salicylamide and phenacetin in tablet form, for quick and lasting relief of pain in strains, sprains, osteoarthritis and bursitis without side effects.

Ciba Pharmaceutical Products, Inc. **Booth No. 319**
Summit, N. J.

FORHISTAL® is a new, low-dosage antiallergic and antipruritic agent. Clinically, FORHISTAL has proved highly effective in a wide range of allergic and pruritic disorders. It is well tolerated by patients of all ages. FORHISTAL is available in 4 forms of issue: Lontabs®, Tablets, Syrup and Pediatric Drops.

Coca-Cola Company **Booth Nos. P-9, P-10**
Atlanta, Ga.

Ice-cold Coca-Cola served through the courtesy and cooperation of the La Salle Coca-Cola Bottling Company, Grand Rapids, Michigan and The Coca-Cola Company.

Desitin Chemical Company **Booth No. 505**
Providence, R. I.

DESITIN OINTMENT: For treatment of burns, ulcers, diaper rash, abrasions, etc.
DESITIN POWDER: Relieves chafing, sunburn, diaper rash, etc.
DESITIN SUPPOSITORIES and RECTAL OINTMENT: Relieve pain and itching in uncomplicated hemorrhoids, fissures.
DESITIN BABY LOTION: Protective, antiseptic.
DESITIN ACNE CREAM: A non-staining, flesh-tinted "Medicream" for the treatment of Acne Vulgaris.
DESITIN COSMETIC & NURSERY SOAP: Supermild.
DESITIN SUPPOSITORIES with HYDROCORTISONE: Prompt response to inflammatory conditions in proctitis, severe pruritus, edema.
DESITIN OINTMENT with HYDROCORTISONE: Provides hydrocortisone 1% (as the Alcohol) added to the well-known Desitin formula of Norwegian cod liver oil.
DESITIN HYDROCORTISONE CREAM: Non-staining, washable hydrophilic base with sol. al. acetate. An elegant cosmetic preparation with HC 1%.
DESITIN C OR-D-TAR CREAM: Desitin Cor-D-Tar Cream—non-staining hydrophilic base with a special solution coal tar 3% and non-staining diodohydroxyquin 2%. For bacterial-fungal-infectious eczematous discomfort.

Dictaphone Corporation **Booth No. 111**
Grand Rapids, Mich.

Displayed are the latest in our product line of Transisterized Thought Recording Instruments. A "Who's Who" of Hospitals, Clinics, Sanatoria, and Professional Men in all specialized fields of medicine, substantiate the time-saving values of Dictaphone products. We welcome you to visit our booth and become better acquainted with our total product line.

Dietene Company **Booth No. 112**
Minneapolis, Minn.

Have you tasted Meritene? Meritene is the good-tasting *Protein*-Vitamin-Mineral Food Supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing Meritene Nourishment.

While there, review also our Dietene Reducing Plan, designed to get better cooperation from overweight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs.

Meritene and Dietene are advertised only to the Medical Profession.

Doho Chemical Corporation **Booth No. 414**
New York, N. Y.

DOHO CHEMICAL CORPORATION IS PLEASED TO EXHIBIT:

AURALGAN Ear medication for relief of pain in Otitis Media; also removal of Cerumen;

RHINALGAN Nasal decongestant free from systemic or circulatory effect. Safe for infants—aged.

OTOSMOSAN Non-Toxic fungicide-bactericide (gram negative-gram positive) for suppurative and aural dermatomycotic ears;

LARYLGAN Soothing throat spray and gargle for infectious and noninfectious sore throat involvements.

BIOTOSMOSAN HC The solution to the "Problem Ear." Antimicrobial, Anti-inflammatory, De-inflammatory, Anti-allergic, Antipruritic

Dome Chemicals, Inc. **Booth No. 415**
New York, N. Y.

Eaton Laboratories, Inc. **Booth No. P-15**
Division of The Norwich Pharmacal Co.
Norwich, N. Y.

FURACIN TOPICAL CREAM—new convenient form and Rx size of Furacin® (nitrofurazone). For treatment of infected surface areas. For treatment and prevention of infections associated with irradiation or surgical removal of external malignant growths. Furacin Topical Cream is particularly suitable for use in postoperative anal, rectal or pilonidal cyst wounds. It facilitates healing, minimizes drainage and malodor. Our representatives will supply you with complete information.

Encyclopedia Americana **Booth No. 309**
Grand Rapids, Mich.

Encyclopedia Americana most cordially invites you to inspect their newly revised 1961 edition featuring *Min-Max* the self-tutoring machine described by *Time* magazine as follows: "The first real innovation in teaching since the invention of movable type during the Fifteenth Century." We also have a souvenir for you without obligation.

Encyclopaedia Britannica **Booth No. 210**
Detroit, Mich.

WILL SHOW 1961 EDITION OF ENCYCLOPAEDIA BRITANNICA SENIOR IN OUR BEAUTIFUL WHITE IMPERIAL BINDING. ALSO ACCESSORIES. BE SURE TO ASK ABOUT OUR EXHIBIT SPECIAL. REPRESENTATIVES ON DUTY: T. ELLIOTT AND P. JOHNSON.

Ferndale Surgical, Inc. **Booth No. 101**
Division of J. F. Hartz Company
Ferndale, Mich.

Geigy Chemical Corporation **Booth No. P-14**
Yonkers, N. Y.

Geigy cordially invites Members and Guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of inflammation, as well as current concepts in the control of hypertension and edema; depression; obesity, and other disorders, which may be discussed with physicians and representatives in attendance.

Gerber Products Company **Booth No. 216**
Fremont, Mich.

NEW! Gerber MODILAC . . . A complete formula for infants. Gently processed to conserve nutritional values, it has true milk color and flavor. Modilac *is* milk adapted to the infant's physiologic requirements by the addition of a selected carbohydrate, replacement of butterfat with corn oil and supplementation with needed vitamins. Ask for complete information.

Great Books of the Western World **Booth No. 511**
Chicago, Ill.

The SYNTOPICON is a huge two-volume 2,428 page "Dictionary of Ideas" compiled under the direction of Mortimer Adler by 100 eminent scholars over an eight year period at a cost of millions of dollars. By means of 163,000 references to 3,000 topics, it instantly guides you directly to each of the Great Authors who have discussed your subject . . . immediately refers you to specific volumes, pages and passages in the GREAT BOOKS where your idea or problem is discussed.

Now—through the development of an amazing new literary invention the SYNTOPICON—you can read and profit from the GREAT BOOKS even if you can spare only minutes a day.

Health Insurance Council **Booth No. 107**
New York, N. Y.

Our exhibit is designed to provide general information on health insurance as underwritten by insurance companies. In addition, it also makes available information on uniform claim forms for use by doctors and hospitals in support of health insurance claims.

H. J. Heinz Company **Booth No. 208**
Pittsburgh, Pa.

Become acquainted with Heinz Baby Foods—over 115 varieties—a complete line of Instant Cereals; Baby Juices with vitamin C; 100% Meats; High Meat Dinners; Vegetables; Vegetable-Meat combinations; Fruits; Puddings and Desserts. Newest of these foods are Apple-Cherry Juice; Junior Peaches with vitamin C added and Strained Creamed Corn.

At the exhibit you will see books on infant feeding and prenatal care and nutritional literature. Pads listing our entire Baby Foods line with ingredients are also available.

Hoekstra Shoe Company **Booth No. 205**
Grand Rapids, Mich.

We will be exhibiting all forms of corrective and orthopedic shoes for men, women and children. Also our display will consist of the different types of construction put into these shoes.

Holland-Rantos Company, Inc. **Booth No. 109**
New York, N. Y.

The H-R exhibit will feature:

. . . Antimycotic (non-messy) *HYVA Gentian Violet Vaginal Tablets;*

. . . Trichomonicidal/fungicidal/bactericidal *NYLMERATE Jelly and Solution Concentrate* for trichomonas and vaginitis and mixed infections;

. . . Medicated *HOLLANDEX Ointment* with Silicones and Natural Vitamins A & D;

. . . Special *KOROMEX* [A] for use when "jelly-alone" is advised for conception control; contouring

KORO-FLEX Diaphragms (facilitate correct placement) and standard *KOROMEX Jelly, Cream, Diaphragms and Sets.*

G. A. Ingram Company **Booth Nos. 302-304**
Detroit, Mich.

The G. A. Ingram Company will have in its booth, for the doctors to stop and see, not only the newest diagnostic and surgical instruments and equipment, but also the latest items to improve procedures and techniques in the doctors' offices.

Johnson & Johnson **Booth No. 320**
New Brunswick, N. J.

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest is SURGICEL Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. DERMICEL Surgical Tape, a special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is also of particular interest. Other products, designed for your office, hospital or patient use, are also displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Knoll Pharmaceutical Company **Booth No. 413**
Orange, N. J.

DILAUDID cough syrup for "the cough that must be controlled"; also DILAUDID ampules for pain that synthetic analgesics frequently fail to relieve. NICOMETRAZOL elixir and tablets have increased the scope of oral METRAZOL therapy, a field in which METRAZOL and Vita-METRAZOL are widely and successfully used in fatigue, geriatric and convalescent patients. QUADRINAL suspension and tablets for asthma. AKINETON tablets and ampules—the new agent for parkinsonism.

A. Kuhlman & Company **Booth No. 402**
Detroit, Mich.

The A. Kuhlman & Company cordially invites you to visit our exhibit where we will have several representatives on hand to discuss with you our complete line of examining room furniture, diagnostic instruments, surgical instruments, and physical therapy equipment.

Lederle Laboratories **Booth No. P-3**
Pearl River, N. Y.

Your Lederle representative will be on hand to serve you. He can furnish information on any Lederle product and is prepared to bring to bear on any of your medical problems the knowledge of the world-wide Lederle research organization.

Eli Lilly & Company **Booth Nos. 517-519**
Indianapolis, Ind.

You are cordially invited to visit the Lilly exhibit located in space Nos. 517 and 519. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

J. B. Lippincott Company **Booth No. P-4**
Philadelphia, Pa.

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

Lloyd Brothers, Inc. **Booth No. 411**
Cincinnati, Ohio

Welcome to the Lloyd Brothers exhibit. Our professionally trained sales representatives will be pleased to greet you and discuss the merits of our products in your practice. Of particular interest will be a new booklet on erythropoietin, the erythropoietic hormone.

P. Lorillard Company **Booth No. 501**
New York, N. Y.

P. Lorillard Company invites you to visit the Kent Cigarette Exhibit.
We are presenting the Story of Kent Cigarettes. And a big part of that story is why you'll feel better about smoking with the taste of Kent.
Kent with the Micronite filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild.
A table cigarette box with your signature in gold will be a pleasant souvenir of your visit to the Convention.

Maico Hearing Service **Booth No. 412**
Grand Rapids, Mich.

An exhibit of the latest in electronic developments relating to: Eyeglass hearing aids, behind the ear hearing aids, and barrette type hearing aids. See the latest development in Electronic Instruments for Auscultation, accomplishes what no Acoustic Stethoscope can. The latest in portable audiometers will be shown, also.

Maltbie Laboratories Division **Booth No. P-7**
Wallace & Tiernan, Inc.
Belleville, N. J.

Maltbie Laboratories features the unique tranquilizer compound, DORNWAL, impressively effective against tension headache and anxiety states. Also displayed are: CALDECORT, an antifungal, antibacterial, anti-inflamamtory dermatologic ointment; DESENEX, for athlete's foot; NESACAINE, a safe, potent and rapid-acting local anesthetic; CHOLANS, for Hepatobiliary dysfunction; and CALDESENE MEDICATED POWDER for diaper rash.

Marion Laboratories, Inc. **Booth No. 509**
Kansas City, Mo.

DUOTRATE

Cardiovascular problems requiring vasodilation can be effectively treated with less expense, less inconvenience and greater therapeutic effect. Duotrate PLATEAU CAPS provide a continuous method of drug release on a b.i.d. dosage—available in four dosage combinations. We invite you to visit our booth for information and reprints of current studies.

Marshall Erdman & Associates **Booth No. 102**
Madison, Wis.

Erdman Prefabricated Medical Buildings are the result of years of experience in the field of design, manufacturing and construction. No other company has had as extensive experience in this field. Over 500 doctors are now practicing in Erdman-built Medical Buildings. Experienced Architects, Engineers and Construction Superintendents of the Erdman Company will design, manufacture and build your Medical Building from the land-planning stage until you open the door into your own office.

S. E. Massengill Company **Booth No. 113**
Bristol, Tenn.

Best wishes from Massengill to the Michigan State Medical Society for a most successful convention!
Our representatives will welcome the opportunity to discuss products of interest to you. On display will be several Massengill specialty preparations, and literature and samples will be available, should you desire them.

Mead Johnson & Company **Booth No. 201**
Evansville, Ind.

Mead Johnson Laboratories will present its line of nutritional and pharmaceutical specialties. Featured in this presentation will be its line of formula products, including Enfamil® Liquid and Powder; vitamin supplements including the new Vi-Sol® Vitamin Drops with Iron and Vi-Sol® Chewable Vitamins as well as its new antiallergic-antipruritic Tacaryl Chewable Tablets.

Mebuco **Booth No. 513**
Mansfield, Ohio

Medco Products Company **Booth No. 419**
Tulsa, Okla.

Presenting the MEDCO-SONLATOR. Providing a new concept in therapy by combining muscle stimulation and ultra sound simultaneously through a SINGLE Three-Way Sound Applicator.

The MEDCO-SONLATOR is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should prove of value to your practice.

Medical Arts Supply Company **Booth No. 410**
Grand Rapids, Mich.

Medical Arts Supply Co. will show in their booth at the Michigan State Medical Society Convention the new equipment as manufactured by the Air Shields Mfg. Co. Also, new Ritter and Hamilton Equipment plus a display of very fine surgical instruments.

Medical Protective Company **Booth No. 103**
Fort Wayne, Ind.

With exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim or suit for damages based on professional services rendered or which should have been rendered. Its experience from the successful handling of 81,000 claims and suits during 62 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Merck Sharp & Dohme **Booth No. P-6**
West Point, Pa.

'LYOVAC' 'THROMBOLYSIN' fibrinolysin (human) for use to promote the dissolution of certain intravascular thrombi is featured.

'ELAVIL', a potent antidepressant agent with a low degree of toxicity, and 'DECADRON', for symptomatic treatment in patients with allergic and inflammatory disorders, are also of interest.

Technically trained personnel will be present to discuss these and other subjects of clinical interest.

Wm. S. Merrell Company **Booth No. 211**
Cincinnati, Ohio

Merrill Lynch, Pierce, Fenner & Smith **Booth No. 114**
Grand Rapids, Mich.

Stock, bond and commodity quotations available at booth by telephone from local office.
Two Account Executives in attendance to assist at all times.
Types of investment booklets available:
"Two Dozen Clues for the Doctor's Successful Investment"
"How To Invest"
"How To Buy Stocks"
et cetera

Michigan Bell Telephone Company **Booth No. 409**
Detroit, Mich.

Michigan Medical Service **Booth No. 306**
Detroit, Mich.

You are cordially invited to visit our booth to obtain current information regarding Michigan Medical Service (Blue Shield). Our representatives will gladly visit with you and answer any questions you may have with regard to your Blue Shield Plan.

Midwest Imports **Booth No. P-1**
Physical Medicine Division
Hinsdale, Ill.

The Physical Medicine Division of Midwest Imports, Hinsdale, Illinois, will exhibit the complete SIEMENS LINE, consisting of:

CARDIOMAT, electrocardiograph with automatic lead and speed marking and push-button control system;

ULTRATHERM, shortwave diathermy machines with automatic tuning and deep-field efficiency—the most advanced in this field;

SONOSTAT, ultrasonic generator featuring a dosage tabulator;

various models of electro-diagnostic and stimulation generators.

Also a complete line of diagnostic instruments.

Few minutes at our booth will prove to be of great importance to you.

Milex Products **Booth No. 115**
Oak Park, Mich.

Milex Products is pleased to announce the release of two new products: (1) a "Teen-Age Guide"; (2) a Fertility Calculator. Also on display will be the new Wide-Seal Crescent, Marital Guide, and Menopause Book, Trimo-San for Treatment Poly-Vaginal Infections, a complete Infertility Line, Amino-Cerv Creme (New Formula) and the Cancer Detection Unit.

Miller Surgical Company **Booth No. 317**
Chicago, Ill.

MILLER SURGICAL CO. Booth No. 317. See the Miller Electro-Surgical Units and accessories, such as Snares, Suction-Coagulation attachments, Grasping Forceps, etc. These Units cut, desiccate, fulgurate, coagulate and may be used for most delicate work up to light major surgery. Also a complete line of Diagnostic Equipment consisting of Illuminated Otoscope, Ophthalmoscope, Eyespud with Magnet, Transillumination Lamps, Mirror Headlite, Vaginal Speculum with Smoke Ejector and Gorsch Operating scopes and stainless steel proctoscopes, all sizes, with magnification. Available also, the Variable Wall Rayostat which converts battery operated equipment to electric.

MSMS Life, Health & Accident **Booth No. P-8**
Insurance Program
Lansing, Mich.

You are cordially invited to stop at Booth P-8 and discuss the MSMS Life, Health and Accident Insurance Program.

Representatives of the MSMS carriers will be present to answer questions concerning your MSMS group coverage.

V. Mueller & Company **Booth No. 315**
Chicago, Ill.

The life-saving Mueller-Moerch Piston Respirator—and Moerch Swivel Tracheostomy Tubes will be demonstrated by V. Mueller & Company. The new Corbin-Farnworth External-Interal Defibrillator and Pacemaker developed for the closed-chest cardiac massage technic—will also be shown.

Mullers Shoes, Inc. **Booth No. 506**
Grand Rapids, Mich.

Our exhibit will show the new Sabel Equino Varus Pre-Walker shoe with Roto-Lok Bar attachments, plus many other of Sabel's basic shoes. We shall also have on display our new line of 100% Straight Last Thomas Heel shoes.

For your interest, Doctor, we have compiled a complete catalog of all types of basic corrective footwear. Please ask us for one.

Wm. R. Niedelson Company **Booth No. 117**
Detroit, Mich.

Pulmonary function and respiratory studies with the new Jones "PULMONOR" will be discussed. "AIR-BASAL" Equipment will also be on display. Office X-Ray examining table model can be viewed.

Noble-Blackmer, Inc. **Booth No. 207**
Jackson, Mich.

You are cordially invited to visit Booth No. 207 while you are at the convention. Noble-Blackmer, Inc.'s friendly representatives will be happy to demonstrate to you the new Birtcher Compact Electrocardiograph, the ever popular 2-A-1 Ritter table, the Liebel-Flarsheim Basalmeter and Office Bovie unit, plus the latest instrument items.

Hermien Nusbaum & Associates **Booth No. 507**
Chicago, Ill.

HERMIEN NUSBAUM and ASSOCIATES, Space 507 invites you to register for samples for personal and office use:

Diaprex and Carbax—Ointments to prevent diaper rash and relieve diaper rash and other skin irritations. Evenflo—glass and boilable plastic bottles; preemie, crosscut and silicone locking nipples; Take Home Formula Pak.

OUR BABY'S FIRST SEVEN YEARS Record Book—offers "Approach to Parenthood" for Prospective Parents Classes and office appointment cards for OB patients.

TFL Dropper—one piece, soft and flexible; will not injure or irritate. Re-usable or extendable.

Ortho Pharmaceutical Corporation **Booth No. 214**
Raritan, N. J.

On display with a complete line of products for conception control are two new forms of the new potent anti-fungal agent, SPOROSTACIN Chlordantoin: SPOROSTACIN Lotion for most forms of fungal dermatitis, and SPOROSTACIN Solution for paronychia and fungal infections of the nails. SPOROSTACIN Cream for monilial vaginitis will also be on display.

Parke, Davis & Company **Booth No. 119-121**
Detroit, Mich.

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Pfizer Laboratories **Booth No. 504**
New York, N. Y.

You are cordially invited to visit the Pfizer Laboratories' booth where our Professional Service Representatives will be pleased to discuss the latest topics of clinical interest.

Procter & Gamble Company **Booth No. 311**
Cincinnati, Ohio

Ivory Soap (Procter & Gamble) offers a series of time-saving leaflet pads for doctors, each pad containing fifty identical tear-out sheets. These sheets, which may be given to patients, contain routine instructions covering six different topics. There are also samples of other free, helpful material prepared especially for physicians. Mrs. Christyne Schwab in charge.

Professional Management **Booth No. 403**
Battle Creek, Mich.

Black & Skaggs Associates
Professional Management
A COMPLETE BUSINESS SERVICE FOR THE MEDICAL PROFESSION.

The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of 29 years and the largest such firm in the country are at their command.

Those attending the 1961 Michigan State Medical Society Annual Session are cordially invited to stop at Booth No. 403 and meet experienced PM executives from the Battle Creek, Detroit, Grand Rapids and Saginaw offices.

Randolph Surgical Supply Company **Booth No. 217**
Detroit, Mich.

Randolph Surgical will display a new low priced quality suite of office furniture, made by a leading medical furniture manufacturer. Also, on hand to greet our many customers will be our experienced personnel.

R. J. Reynolds Tobacco Company **Booth No. 301**
Winston-Salem, N. C.

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, WINSTON Filter, Menthol Fresh SALEM or CAVALIER King Size Cigarettes.

A. H. Robins Company, Inc. **Booth No. 420**
Richmond, Va.

For relieving many symptoms of the season's common colds, prescribe DIMETAPP EXTENTABS and DIMETANE EXPECTORANT. DIMETAPP EXTENTABS provide the unexcelled antihistaminic properties of *Dimetane* plus the decongestant actions of *phenylephrine* and *phenylpropanolamine*. With *glyceryl guaiacolate* these same compounds form DIMETANE EXPECTORANT.

For superior expectorant action alone, prescribe ROBITUSSIN. And for a therapeutic multivitamin, ADABEE.

Roche Laboratories **Booth No. 520**
Nutley, N. J.

LIBRIUM—A therapeutic agent for superior, safer, faster control of nervousness, anxiety, tension and other common emotional disturbances without the dulling effect or depressant action of the tranquilizers.

TIGAN—A specific antiemetic agent effective both prophylactically and therapeutically against most clinically significant types of nausea and vomiting.

J. B. Roerig & Company **Booth No. 212**
New York, N. Y.

J. B. Roerig and Company will welcome members of the medical profession at the company's exhibit of leading specialties and new products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

Wm. H. Rorer, Inc. **Booth No. 108**
Philadelphia, Pa.

MAALOX, a pleasant tasting, non-constipating antacid, is featured in Suspension, Tablets No. 1 and Tablets No. 2. Also highlighted are ASCRIPTIN, a professional salicylate for pain of arthritis, FERMA-

LOX, a non-irritating, uncoated, buffered ferrous sulfate tablet, and PAREPECTOLIN, a pleasant tasting antidiarrheal preparation of Paregoric, Pectin and Kaolin.

Representatives will gladly answer questions concerning Rorer products.

Ross Laboratories **Booth No. 105**
Columbus, Ohio

Ross Laboratories, manufacturer of Similac, features SIMILAC WITH IRON, supplying 12 mg. of ferrous iron per quart of feeding. SIMILAC WITH IRON is designed for use when exogenous iron is indicated in infancy to support the usual diet, and to provide prophylaxis against iron depletion starting about the fourth month or 14 pounds. The newest booklet in the Ross Developmental Aids will be on display at the booth.

C. J. Rouser Supply Company **Booth No. 209**
Lansing, Mich.

Superior ventilation and pulmonary treatment are easily achieved with the new Simplex model of the Bird Mark 7 Respirator. Long-time management of Cystic Fibrosis-Chronic Bronchospasm-Emphysema. Many of these treatments are now being given in the doctor's office.

Also Micronefrin Bird's new Bronchodilator and Jone's Pulmonor for Simplified Waterless Pulmonary Function Testing.

Rupp & Bowman Company **Booth No. 405**
Highland Park, Mich.

Doctors, you are cordially invited to stop in at our booth. Hope to have new items of interest to you.

Sanborn Company **Booth No. 516**
Waltham, Mass.

The new SANBORN/FROMMER CELL COUNTER as well as new ELECTROCARDIOGRAPHS of advanced design and function together with the latest models of other instruments for diagnostic use, will be displayed and demonstrated at the Sanborn Company Booth No. 516.

Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multi-channel recording systems, monitoring oscilloscopes and physiological transducers.

Qualified Sanborn representatives will be pleased to answer questions and assist you with technical problems.

Sandoz Pharmaceuticals **Booth No. 318**
Hanover, N. J.

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth No. 318.

MELLARIL—the first potent tranquilizer with a selective action (i.e.—no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels.

TORECAN—as a sequel to the original research which led to the synthesis of Mellaril, a tranquilizer relatively devoid of antiemetic activity, the Sandoz Laboratories have now succeeded in developing a potent antiemetic with little or no tranquilizing properties. Accordingly, this compound, *TORECAN,* constitutes a more specific antiemetic and the results obtained to date indicate that it is a promising agent for the treatment of nausea and emesis of diverse etiology.

CAFERGOT PB—the most effective oral medication for the relief of migraine headache with G. I. disturbance accompanied by tension.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company **Booth No. P-2**
Philadelphia, Pa.

Harold Rozema will again be on hand with the complete Saunders line. New titles since last year's meeting include: Edwards: Atlas of Heart Disease; Pillsbury et al: Dermatology; White: Kidney Diseases; Sodeman: Pathologic Physiology; Rubin: Diseases of the Chest; and Tenney & Little: Clinical Obstetrics.

Julius Schmid, Inc. **Booth No. 407**
New York, N. Y.

An interesting and informative exhibit featuring IMMOLIN Vaginal Cream-Jel for use without a diaphragm; RAMSES Flexible Cushioned and BENDEX Diaphragm; Ramses Vaginal Jelly; VAGISEC Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES, SHEIK and ESQUIRE Rubber Condoms for the control of trichomonal re-infection.

G. D. Searle & Company **Booth No. P-16**
Chicago, Ill.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Smith, Kline & French Laboratories **Booth No. P-5**
Philadelphia, Pa.

Our Representatives welcome the opportunity to discuss SK&F products with you and are always ready to be of help in any way they can. Products featured are: (1) Stelazine® Tablets; (2) Parnate® Tablets; (3) Eskatrol® Spansule® capsules; (4) Thorazine®; (5) Ornade® Spansule® capsules.

E. R. Squibb & Sons **Booth No. 308**
New York, N. Y.

E. R. Squibb & Sons has long been a leader in development in new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

At Booth No. 308, we are pleased to present up-to-date information on these advances for your consideration.

Standard Process Laboratories **Booth No. 417**
Milwaukee, Wis.

Standard Process Laboratories will feature Ribo Nucleic Acid and Enzyme formulas for treating Chronic and Degenerative diseases, including Proteolytic Enzyme therapy, for complete protein breakdown, making the amino acids available to Geriatrics; also three different HCl formulas for Hypochlorhydria cases. Some new digestive formulas, containing all natural elements acceptable to the digestive system, may also be displayed.

Strasenburgh Laboratories **Booth No. P-17**
Rochester, N. Y.

You will learn—

How 'Biphetamine', 'Ionamin', and 'Biphetamine-T' can assist in achieving sustained weight loss in exogenous obesity!

How a single dose of 'Tussionex' will control coughs for 8-12 hours!

How 'Akalon-T' provides 8-12 hours relief from the pain of hyperacidity and hypermotility!

How sustained ionic release (Strasionic Release) makes all five of these products unique and effective!

The Stuart Company **Booth No. P-18**
Pasadena, Calif.

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be

in attendance to answer your questions on new products developed in our new and modern laboratories which have received international acclaim.

Testagar & Company **Booth No. 408**
Detroit, Mich.

Testagar & Co. invites you to stop at Booth 408 to see the newest release, "Redoderlein—Replacement Doderlein Bacillus Therapy." Doderlein Bacillus is a recognized therapy in convenient, stable, readily available form. Redoderlein may be the therapy of choice in vaginitis; trichomonas, monilial, senile or nonspecific. Stop at Booth 408 and receive literature on the newest concept in the treatment of vaginitis.

S. J. Tutag & Company **Booth No. 418**
Detroit, Mich.

S. J. Tutag & Company will exhibit Cydril, the new anti-obesity product exhibiting low CNS stimulation properties. Information regarding other Tutag quality products will be available. Our representatives will be pleased to meet you and answer your questions.

U. S. Vitamin & Pharmaceutical Corp. **Booth No. 515**
New York, N. Y.

D B I, "full-range" oral hypoglycemic agent, is a brand of phenformin (N^1-B-phenethylbiguanide). D B I is distinctly different in chemical structure and physiologic action from the oral hypoglycemic sulfonylureas, and effectively lowers blood sugar in mild, moderate and severe diabetes. D B I, used alone, satisfactorily lowers elevated blood sugars in as high as 88 per cent of stable adult diabetics . . . and successfully restores to oral control significant numbers of primary and secondary sulfonylurea failures. In combination with insulin, D B I improves regulation of "brittle" adult and juvenile diabetes and is also effective in many insulin-resistant cases. Full details available.

The Upjohn Company **Booth No. P-13**
Kalamazoo, Mich.

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Vaponefrin Company **Booth No. 310**
New York, N. Y.

Wallace Laboratories **Booth No. 312**
New Brunswick, N. J.

Warren-Teed Products Company **Booth No. 518**
Columbus, Ohio

The Warren-Teed Products Company will feature the following pharmaceutical specialty products at their exhibit.
Ilocalm Tablets—Antiulcerogenic plus anticholinergic management of peptic ulceration.
Ilomel Powder—Antiulcerogenic plus antacid management of peptic ulceration.
Ilopan—An injectable d-pantothenyl alcohol for the treatment and prevention of flatulent gastrointestinal distention.
Warren-Teed representatives cordially welcome all registrants to visit their display.

Westwood Pharmaceuticals **Booth No. 307**
Buffalo, N. Y.

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:

Fostex Cream	Lowila Cake	Sebulex
Fostex Cake	Lowila Emollient	Fostril
		Alpha-Keri

These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories **Booth No. 204**
Kenilworth, N. J.

White Laboratories exhibit features Sorboquel tablets—the result of a decade of laboratory experimentation and over five years of clinical confirmation. Sorboquel, a totally new agent for truly effective control of both chronic and acute diarrhea, has been demonstrated effective in 85% of chronic and 94% of acute cases of diarrhea.

This exhibit also features Entoquel Syrup. A new gastrointestinal antimotility agent for fast, effective, and economical treatment of pediatric diarrhea. Entoquel is not an opiate, and has successfully stopped diarrhea where kaolin pectin suspension has failed.

Winthrop Laboratories **Booth No. 406**
New York, N. Y.

Trancoprin, a new non-narcotic analgesic which relieves pain and relaxes skeletal muscle spasm safely and effectively. It also has a mild tranquilizing effect.

Isuprel Elixir, a new balanced expectorant bronchodilator which contains three antiasthmatics—Isuprel, ephedrine, theophylline—with the expectorant, potassium iodide, and Luminal for a mild sedative effect.

Call to Arms

Detroit Medical News, June 12, 1961

We have heard it said that people may be divided into three kinds. First, the very small number who make things happen; second, the somewhat larger number of people—the intelligent, well-informed, educated people, who watch things happen; and finally the largest segment—those who don't know anything is happening.

Physicians, as a rule, are among the most educated people in their community. Their daily association with humanity with its mask off, increases their sensitivity, insight and sense of reality.

However, there is in our educational process the "scientific" method of training ourselves to see all sides of every question. This is valuable, but we have failed to take the next logical step. After seeing all sides, we are *obligated*, if we want anything to happen, to decide in favor of one stand and to know the reasons why. Many of us are so tolerant of all views that we have none of our own which we are willing to fight for. Meanwhile, those who take a stand and fight for it with a passion are the ones who change the course of human events. It is time for physicians with their unique gifts to examine in detail all their personal values, weigh them carefully, then decide where to stand, and come up fighting.

Let's stop being watchers. Let's make things happen.

The Weeders, Van Gogh, Bernard Koehler Collection, Berlin

STRAIN

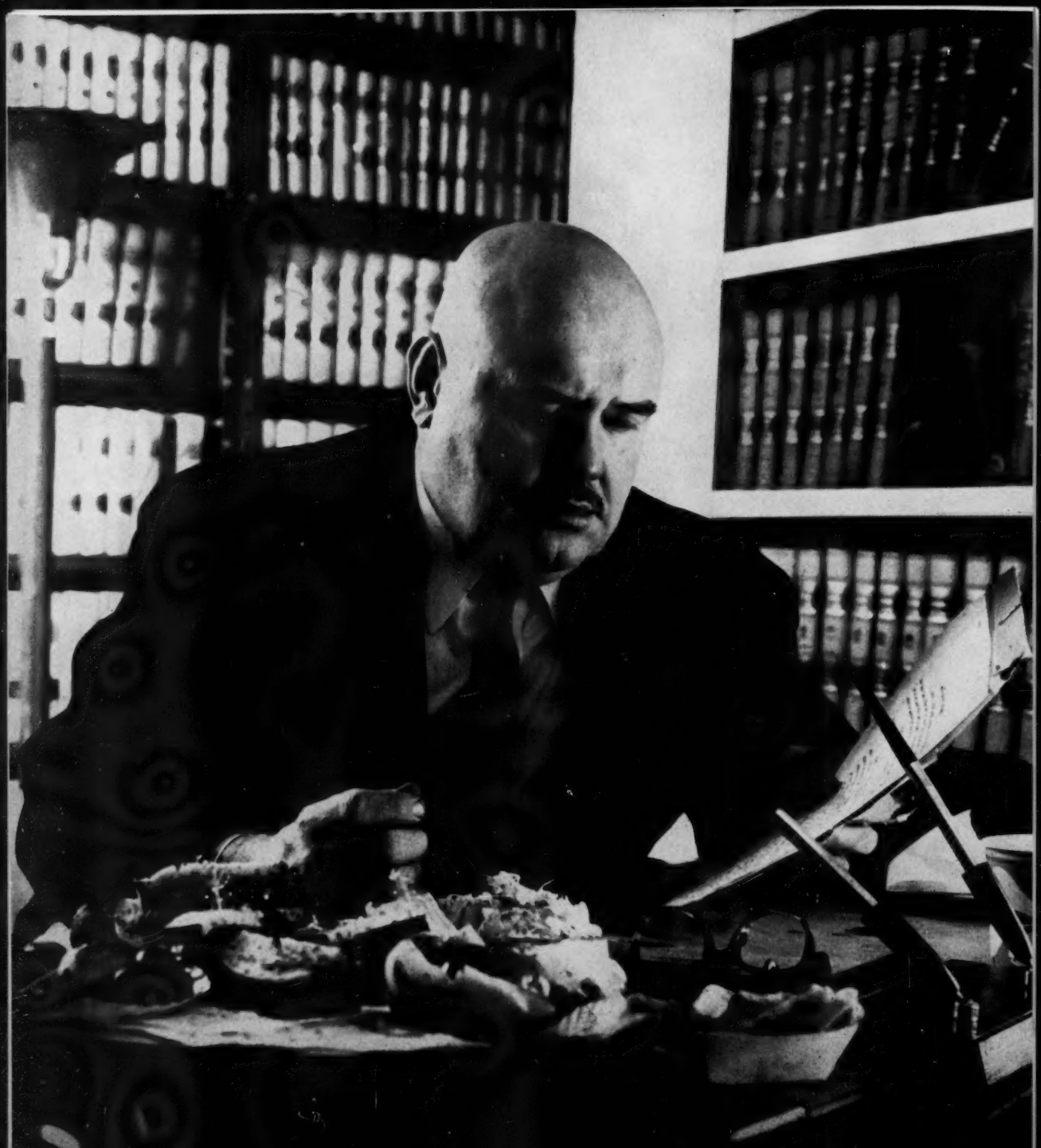
Essential in moving external masses, but potentially dangerous in moving the bowels, since vascular accidents may be precipitated in heart patients by excessive straining at stool. For cardiac patients with constipation, Metamucil adds a soft, bland bulk to the bowel contents to stimulate normal peristalsis and also to hold water within stools to keep them soft and easy to pass. Thus Metamucil, with an adequate water intake, induces natural elimination with a minimum of straining. Metamucil also promotes regularity through "smooth-age" in all types of constipation.

brand of psyllium hydrophilic mucilloid ®

Metamucil

Available as Metamucil powder or as the new lemon-flavored Instant Mix Metamucil

SEARLE



for "special-problem" patients... when corticosteroid therapy is indicated

Aristocort®

in rheumatoid arthritis

Aristocort®

Triamcinolone LEDERLE

UNSURPASSED "GENERAL-PURPOSE" STEROID
OUTSTANDING FOR "SPECIAL-PURPOSE" THERAPY

ARISTOCORT Triamcinolone has long since proved its *unsurpassed efficacy and relative safety* in treating rheumatoid arthritis. Mounting clinical evidence has shown that ARISTOCORT is also highly valuable for the "special-problem" arthritic – the patient who, because of certain complications, was hitherto considered a poor candidate for corticosteroids.

for example:

SPECIAL PROBLEM: ANXIETY-TENSION

When triamcinolone was used, euphoria and psychic unrest rarely occurred. (McGavack, T. H.: *Clin. Med.* 6:997 [June] 1959.)

SPECIAL PROBLEM: OVERWEIGHT

No patient developed voracious appetite on triamcinolone. Preferable for the overweight person whose appetite is undesirably stimulated by other steroids. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

SPECIAL PROBLEM: EDEMA

Since it does not produce edema, triamcinolone is useful in rheumatoid arthritis patients with cardiac decompensation who need steroid therapy. (Hollander, J. L.: *J.A.M.A.* 172:306 [Jan. 23] 1960.)

SPECIAL PROBLEM: HYPERTENSION

Triamcinolone may be included among the currently available antirheumatic steroids having the least tendency to cause sodium retention. (Ward, L. E.: *J.A.M.A.* 170:1318 [July 11] 1959.)

Hypertension did not result from triamcinolone therapy. Existing hypertension was reduced sometimes. This may have been due to lack of sodium retention. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of rheumatoid arthritis, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).
Also available—syrup, parenteral and various topical forms.

Lederle

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Division of Laboratories to Discontinue Some Services

Effective July 3, 1961, the Division of Laboratories will discontinue the performance of blood groupings, Rh type determinations, anti-Rh and ABO titrations, and all blood and urine chemistry determinations.

This change *will not* affect those state institutions which do not have their own laboratory facilities or those agencies with whom the state health department has contractual agreements.

Organizational Changes

As of July 3, 1961, the Division of Disease Control, Records and Statistics was abolished. In its place, the Division of Epidemiology was established under the direction of Dr. George Agate. The Sections of Vital Records and of Statistical Methods have been transferred to the Division of General Services (formerly Administrative Services) and the Section of Education has been transferred from the Division of General Services and has become the Office of Public Health Information Services.

Diabetes Detection

In the first three months of this year, 7,833 persons were screened for diabetes in Detroit. As a result of these screening tests, thirty persons were found to have diabetes without knowing it. Data from this program substantiate the fact that diabetes is found much more frequently as people get older. The rate for new cases diagnosed increased from 2.0 per 1,000 in the age group 20-44 to 15.9 per 1,000 in the age group 75-84.

Grant-in-Aid

The establishment of a grant-in-aid entitled "The Isolation of Human Placental Fibrinolysin" was approved by the National Institutes of Health for a two-year period from May, 1960, through April 1963. The purposes of the investigation are:

1. To develop procedures for the isolation and purification of profibrinolysin (plasminogen) from hemolyzed placental and intrapartum blood;

2. To study some of profibrinolysin's chemical and physical properties and to study its conversion to the active fibrinolytic principles, fibrinolysin (plasmin); and

3. To make both profibrinolysin and fibrinolysin available in sufficient quantity and quality for (a) use by ourselves and regulating agencies as reference laboratory standards and (b) its *in vitro* and *in vivo* evaluation as a thrombolytic agent.

Antibiotic Research

Research continues in the development of new and useful antibiotics. A total of 14,622 samples of antibiotic substances has now been submitted to the National Cancer Institute for screening against cancer cells. Of these, sixty-seven have shown marked anti-cancer activity. Ten substances were eliminated as being impractical. Twelve substances are now being developed for more advanced investigation.

Conductive Flooring in Hospitals

The department is continuing to study the failure of conductive flooring used in hospital operating and delivery rooms. Testing during May indicated that terrazzo conductive flooring in a new hospital did not meet safety standards. This discovery was made prior to the opening of the hospital. Visits to two other hospitals with the same type of flooring constructed within the past two years indicated that attempts to rejuvenate this flooring have so far failed. The problem has been called to the attention of the flooring contractors, Terrazzo Institute, the National Fire Protection Association, and the State Fire Marshal.

Discontinue Measuring Fallout

After six years of round-the-clock monitoring, the Michigan Department of Health discontinued measuring radioactive fallout on June 11, this year. The monitoring was halted because readings over the past one and one-half years have remained at normal levels since the cessation of nuclear testing.

During the six years in which fallout was monitored, it was determined that Michigan is in a higher than average fallout area. However, although there were sharp increases in fallout over Michigan during nuclear testing periods, concentrations never reached levels considered dangerous by established standards. If nuclear testing should be resumed in the future, the department will again begin to measure radioactive fallout.

Many from Michigan On AMA Program in NYC

Medical discipline, surgical assistants, drug legislation, relations with allied health professions and services, and many other subjects were covered by 115 resolutions and 28 reports acted upon by the House of Delegates at the American Medical Association's 110th Annual Meeting held June 25-30 in New York City.

George M. Fister, M.D., of Ogden, Utah, member of the AMA Board of Trustees, was named president-elect of the Association. Dr. Fister will become president at the June, 1962, annual meeting in Chicago, succeeding Leonard W. Larson, M.D., of Bismarck, North Dakota, who assumed office in New York.

The AMA 1961 Distinguished Service Award was voted to Walter H. Judd, M.D., of Minneapolis, physician and member of Congress, for his contributions as a medical missionary, humanitarian and statesman devoted to world peace.

* * *

THE SCIENTIFIC PROGRAM of the American Medical Association Annual Session is in reality the raison d'etre of the convention. The administrative and legislative affairs are indispensable, and have received brief consideration considering their importance.

Many physicians from Michigan devoted their time and made their contributions. Those listed had some part in presenting papers, moderating panels, taking part in formal discussions, in the exhibits, and as section officers. Unless otherwise mentioned, the following are all M.D.'s:

From Ann Arbor: William H. Beierwaltes, Leonard F. Bender, Edward A. Carr, Arthur C. Curtis, Winthrop N. Davey, Russell N. DeJong, Marion S. DeWeese, Ivan F. Duff, Harold F. Falls, Conrad L. Giles, Richard J. Ging, Karen A. Gustafson, Thomas P. Haynie, James H. Heakaman, Gerald Hover, Jo D. Isaacson, William Martel, James G. Miller, Seward E. Miller, George W. Morley, Mohammed M. Noral, Julius A. Parker, M.A.; H. Marvin Pollard, James W. Rae, Jr., William W. Tourtellotte, Ph.D., Albert H. Wheeler, Ph.D., Chris J. D. Zaraeonetis.

From Detroit: Walter L. Anderson, D. F. Armento, J. E. Berk, Richard J. Bing, A. W. Bohne, George C. Bower, J. B. Bryan, Lucian Campeau, Max D. Clark, Wyman C. C. Cole, Sr., William R. Eyler, Robert P. Fosnaugh, Boy Frame, Michael C. Geokas, Robert A. Gerisch, James H. Greer, Ph.D., R. J. Hartsock, C. Paul Hodgkinson, Robert Horn, Jr., W. Leonard Howard (Northville), Funan Hu, R. Ross Hume, R. B. Hunter, Aran S. Johnson, H. L. Johnson, Kenneth L. Krabbenhoft, Edward A. Krull, Conrad R. Lam, Traian Leucutia, Clarence S. Livingood, W. L. Lowrie, Lucile Marsh, Amir H. Mehregan, Richard R. Menard, W. C. Mieher, Robert C. Moehle, R. S. Ormond, Herman Pincus, Dwight H. Porter, W. E. Redfern, Roger I. Rian, Walter H. Seegers, Ph.D., Edward J. Shumaker, John W. Sigler, R. D. Urwiller, George L. Waldbott, F. W. Whitehouse.

FOLLOWING ARE brief descriptions of some of the AMA actions:

Medical Discipline

As a major move designed to strengthen the profession's disciplinary mechanisms, the House approved the conclusions and recommendations of the Medical Disciplinary Committee, with only three word changes.

One recommendation suggests that "The bylaws of the American Medical Association be changed to confer original jurisdiction on the Association to suspend or revoke the AMA membership of a physician guilty of a violation of the Principles of Medical Ethics or the ethical policy of the American Medical Association regardless of whether action has been taken against him at local level."

Another "encourages and urges that each state association report annually to the American Medical Association all major disciplinary actions taken within its jurisdiction during the preceding calendar year." The report urged state and county medical societies to utilize grievance committees as "grand juries" to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member.

Communications

The House adopted a substitute resolution directing the Speaker of the House of Delegates to name seven elected members of the House as a special committee "to study and continually advise the Board of Trustees on the broad planning and coordination of all phases of communications of the American Medical Association, so that the public and the members of the medical profession are properly and adequately advised of the policies and concern of the medical profession with respect to all phases and aspects of medical care for all people." The House agreed with a reference committee opinion that "we have a very adequate Division within the AMA capable of implementing any program of communications."

Surgical Assistants

The House approved the following five basic principles developed by the Judicial Council and the Council on Medical Service:

"1. Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional

charge should be made or for which a fee may be ethically paid or received.

"4. It is ethically permissible for a surgeon to employ other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance.

"This principle applies whether or not an assisting physician is the referring doctor and whether he is on a per-case or full-time basis. The controlling factor is the status of the assisting physician. If the practice is a subterfuge to split fees or to divide an insurance benefit, or if the physician is not actually employed and used as a bona fide assistant, then the practice is contrary to ethical principles.

"5. Under all other circumstances where services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately."

Efficacy of Drugs

The House strongly endorsed a Board report which pointed out the problems that would result from amending the Food, Drug and Cosmetic Act to authorize the Food and Drug Administration to determine the efficacy, as well as the safety, of a prescription drug prior to the approval of a new drug application. The report contended that "a decision with respect to the effectiveness of drugs is dependent upon extended research, experimentation and usage." The House agreed that vesting such authority in the Food and Drug Administration would operate to limit research, the marketing of drugs and the exercise of discretion by the medical profession.

General Practice Residencies

Eight resolutions were introduced on the subject of creating new two-year, residency training programs in general practice. The House agreed that there appears to be a need for such programs for those individuals who desire more experience in obstetrics and surgery than may be available in the currently existing Family Practice Program. It approved a substitute resolution directing the Council on Medical Education and Hospitals to consider for approval other two-year programs in general practice which incorporate experience in obstetrics and surgery.

Relations with Other Health Professions and Services

The House considered a Board report and twelve resolutions dealing with various aspects of medicine's relationships with allied health professions and services, including optometry. The Board report recommended the creation of a new AMA Council to handle all the problems involved. The House, however, accepted a

reference committee suggestion for establishment of a new Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services, with subcommittees to consider problems in specific areas.

Polio Vaccine

The House approved a report by the Council on Drugs on the present status of poliomyelitis vaccination in the United States and urged that it be made available to all physicians through the most effective communications media. The report emphasizes that "physicians should encourage, support and extend the use of Salk vaccine on the widest possible scale at least until the oral polio-virus vaccines currently under development and clinical trial become available."

Osteopathy

In considering a report of the Judicial Council and three resolutions on the subject of osteopathy, the House of Delegates agreed with the intent of the report and resolutions, but instead adopted the following statement of AMA policy:

"1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.

"2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

"3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

"4. It is appropriate for the American Medical Association to *reappraise its application of policy* regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

"5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the AMA, voluntary professional relationship with him should not be deemed unethical."

Miscellaneous Actions

In dealing with resolutions and reports on a wide variety of other subjects, the House also:

Approved the *"Guides to Physician Relationships with Medical Care Plans,"* submitted by the Council on Medical Service, with two changes;

Reaffirmed its support of the *Kerr-Mills* program for the needy and near-needy aged and its opposition to any legislation of the *King-Anderson* type, declaring that the medical profession "will not be a willing party to implementing any system which we believe to be detrimental to the public welfare";

Approved a markedly expanded *drug information program* submitted by the Board of Trustees and the Council on Drugs;

Decided to hold the *1963 Clinical Meeting* in Portland, Oregon, instead of Las Vegas, Nevada, as recommended by the Board;

Approved a plan by the new AMA Department of International Health to cooperate in the recruitment of volunteer physicians for emergency medical service in *foreign mission fields*;

Agreed to an increase of $20 in the annual AMA *membership dues* to be implemented over a period of two years: $10 on January 1, 1962, and $10 additional on January 1, 1963;

Discontinued the Association's *General Practitioner of the Year* award;

Opposed legislative and administrative mandates which would compel physicians to prescribe drugs, or require pharmaceuticals to be sold, by *generic names* only;

Reaffirmed the Association's opposition to compulsory inclusion of physicians under the *Social Security* system;

Urged immediate legislation that will provide strong economic motivation for the construction and maintenance of *fallout shelters*;

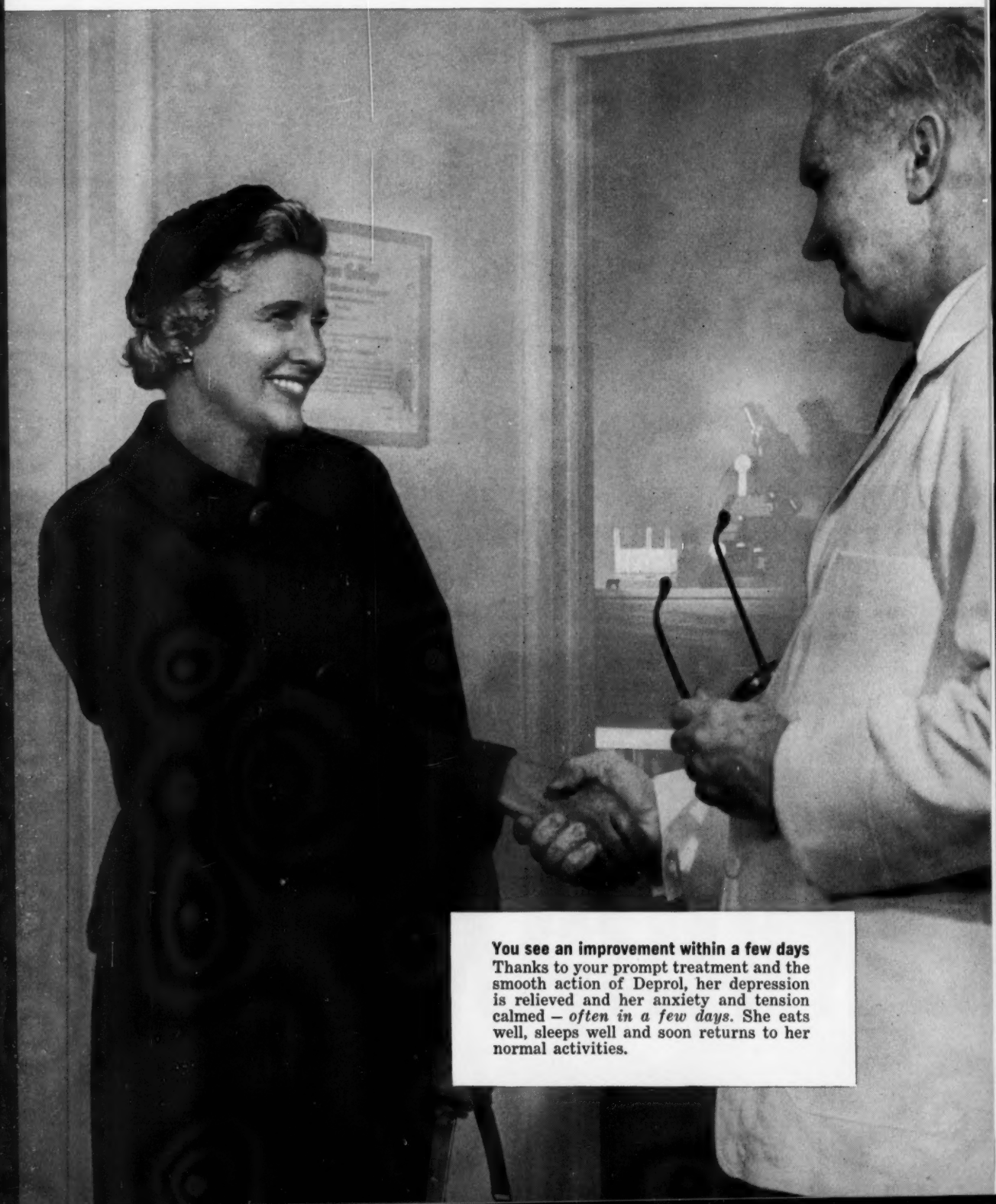
Disapproved two resolutions which would have discontinued the scientific activities at the *Clinical Meeting*;

Urged *immunization campaigns* against both tetanus and influenza, and

Asked state and county medical societies to give full support to the *First National Congress on Medical Quackery* to be jointly sponsored next October 6-7 in Washington, D. C., by the AMA and the Food and Drug Administration.

The seventeenth Annual Conference of Presidents and Other Officers of State Medical Associations drew the largest and most enthusiastic attendance in its history.

Lifts depression....



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *–they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation*–they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety–both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients):* **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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Tell School Counselors Needs of Professions

Channels of communication were widened and deepened between high school counselors and the professions at a summer conference sponsored by the Michigan Association of the Professions.

Several leaders of the Michigan State Medical Society along with other professional society representatives participated in the week-end conference held at Alma College.

* * *

ONE OF THE MAJOR speakers was Lyman J. Smith, Ph.D., new director of the AMA scholarships program. He related his experiences as the former director of the Illinois Scholarships Commission and outlined his AMA plans. Earle S. Oldham, M.D., Breckenridge, MSMS councilor, served as official host for Mr. Smith.

The "MAP Conference with School Counselors" was developed by the MAP Committee on Education and was endorsed at the Second MAP Congress. Serving on the Committee on Education, which this spring also held a Professions Career Day at Saginaw, are William N. Hubbard, M.D., dean of the University of Michigan medical school, and Dean Gordon H. Scott of the Wayne State University medical school.

Participating in the conference with the deans or their representatives were counselors and professional men. The counselors represented junior-high, senior-high and college levels.

Working closely with MAP to present the conference were the leaders of the Michigan Counselors Association. Contributing to a conference panel discussion was Donald Fink, of Grand Rapids, president of the Counselors organization.

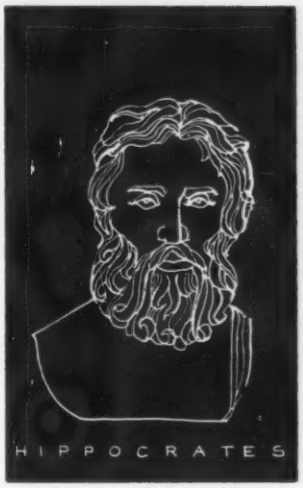
In addition to the speakers, panels and workshops, the conference featured an exhibit of available materials from the various professions. The counselors voiced their appreciation for these "helps."

Timed with the conference, the scholarship and recruiting committees of several of the state professional organizations met at Alma on the same days.

* * *

THE CONFERENCE CONCLUDED with a workshop session, when all participants stressed their desire to have another conference in 1962. It was suggested that the conference be held during the school year, in the spring, to permit more counselors to attend.

Various year-around, on-going activities were suggested by both the counselors and the professional men. William R. Mann, D.D.S., of the University of Michigan Dental School and chairman of the MAP Committee on Education, has assured that many of these activities will be pursued. Dr. Mann, in his remarks, thanks members of his committee and Alma College officials for their excellent cooperation in presenting this project.



Hospital Representatives Attack MCCC Payments

Representatives of the Michigan Hospital Association made an appeal that hospitals rendering care under the provisions of the Michigan Crippled and Afflicted Children's Act "should be reimbursed at the cost of providing such care."

The statements were made June 29 at the hearing of the Joint Legislative Interim Committee to Review the Administration of the MCCC program.

The hospital officials contended that Michigan hospitals have lost over $10 million in the past 10 to 15 years because the MCCC reimbursement does not meet the costs.

The officials pointed out that the losses have to be recovered and that "generally speaking, these losses are recovered by charging other non-governmental patients sufficiently high rates to overcome the deficit." It was reported that a study of hospital costs at a major institution showed that governmental patients met 62 per cent of the cost of their care, Blue Cross patients 100 per cent and private-paying patients met 117 per cent.

The hospital association representatives stated that "such subsidies on the part of sick patients for the care of patients who are the responsibility of government is neither fair nor equitable." Four improved payment plans were suggested.

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For example, extensive studies are now being carried out in organic synthesis, vaccines, and radioactive isotopes. Some of these pharmaceuticals and biologicals are presently undergoing clinical trials in this country.

One research project nearing completion is a measles vaccine, now undergoing extensive U. S. clinical trial. Another preparation, soon to be available, is a progestational agent which gives promise of offering distinct advantages over those presently available. A true progestin, it will have wide application in female disturbances without androgenic, estrogenic, or corticosteroid side effects.

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PROGRESS IN RESEARCH FOR MEDICINE

Brief and to the Point

ENDS LONG SERVICE—Walter H. Rozine, M.D., Morenci, recently terminated 19 years as a member of the Morenci city council. The council adopted a resolution paying tribute to Dr. Rozine's service and loyalty.

* * *

CITIZEN OF THE YEAR—A. M. Rothman, M.D., recently was honored as "East Detroit's Citizen of the Year." Doctor Rothman was nominated by the East Detroit Chamber of Commerce for the honor. His list of civic activities includes 10 years on the city's civil service board. Doctor Rothman, who began his practice in East Detroit in 1926, was lauded by the mayor as a "dedicated doctor, who gives freely of his time and energy to help people without thought of remuneration."

* * *

ON MSU PROGRAM—Four doctors were special lecturers at the recent Workshop on Rehabilitation of the Disabled Homemaker at Kellogg Center. They included John G. Bielawski, M.D., Michigan Heart Association; Raymond H. Murray, M.D., Grand Rapids; Joseph N. Schaeffer, M.D., Rehabilitation Institute, Detroit, and Robert M. Stow, M.D., Lansing.

* * *

FEATURED—Articles by several Michigan doctors are featured in the Special Gerontotherapy Issue of *The New Physician*, SAMA publication, for July. Michigan writers in the spotlight included W. N. Hubbard, Jr., M.D., dean of the University of Michigan Medical School; Clarence E. Crook, M.D., Winslow G. Fox, M.D., Frederic B. House, M.D., John Tipton, M.D., C. Howard Ross, M.D., all of Ann Arbor.

* * *

HONORED—Harry E. August, who recently completed 10 years as chief of the psychiatric outpatient department at Sinai Hospital, was honored at a dinner at the Wayne County Medical Society building. He told the group that his proudest achievement was the recent opening of the 40-bed unit at Sinai for the mentally ill with both a "night" and "day" hospital.

* * *

CITED FOR CIVIC WORK—Remus Robinson, M.D., Detroit, member of the Detroit Board of Education, received the "Physician of the Year" award recently at the meeting of the Detroit Medical Society's Annual Clinic Day.

* * *

RECOGNIZED—The recent St. Luke's Hospital intern-resident dinner at Saginaw featured the presentation of several awards. Louis D. Gomon, M.D., was named the "outstanding physician of the year" and Robert J. Toteff was honored as the "physician who had offered the most help to the house staff."

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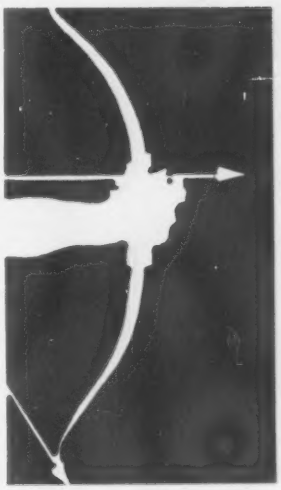

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HONORED—A. Hazen Prize, M.D., Detroit, Chairman of the MSMS Geriatrics Committee, was presented a citation for outstanding service to older people at the University of Michigan's 14th annual Conference on Aging. The citation presented read in part "skilled in the arts of your profession and dedicated to your community and to your state, your leadership in the field of aging has brought enormous benefit to the older people of Michigan."

* * *

OFFERS SCHOLARSHIPS—The Oklahoma State Medical Association has established a loan and scholarship fund at the University of Oklahoma School of Medicine supported by a $5 increase in annual dues. Assessment is expected to yield $7,500 per year, with $3 of each $5 collected earmarked for loans and $2 for scholarships and grants-in-aid.

* * *

ORDERS SAFETY BELTS—Connecticut's Governor ordered all new cars purchased by the state from now on to be equipped with safety belt mountings. He believes belts will help reduce injuries as well as costs of state compensation and insurance claims.

* * *

QUIZ HOSPITALS—Several Michigan hospitals are being surveyed by the Hospital Planning Association of Allegheny County study of community health activities at general hospitals. The purpose of the study is to determine what factors make hospitals centers of health activities in their communities and the kinds of services offered in these centers.

* * *

RESEARCH FELLOWSHIPS—Summer research fellowships for $500 were again offered by the Tobacco Industry Research Committee. "This program, now in its seventh year, is designed to encourage students to make a career in research. For those who enter other fields of medicine, it will provide valuable exposure to research," according to the committee.

* * *

NURSING HOME STUDY—The University of Michigan has launched a two-year study of nursing home costs. The purpose of the study is to find the cost of the patient services that can and should be provided by nursing homes. This is necessary for evaluating and perhaps revising payment policies to such institutions. The Social Security Administration has given $32,729 to support the first year of the investigation.

* * *

LOCATED—M.D. Locations in Michigan in March, April, May, June, as recorded by the Michigan Health Council:

Placed by Michigan Health Council: David B. Witte, M.D., in South Haven, Alex E. Solik, M.D., in Flint, Robert Sosa, M.D., in Ishpeming, Kenneth T. Woodsides, M.D., in Albion, and Alvin J. Ratzlaff, M.D., in Hart.

Assisted by Michigan Health Council: John A. Lusk, M.D., in Davison.

* * *

DETAILS AVAILABLE—The American Board of Obstetrics and Gynecology will hold its next scheduled examination, (Part I), written, held in various cities January 5,

(Continued on Page 1094)

(Continued from Page 1092)

1952. Information may be obtained from Robert L. Faulkner, M.D., Executive Secretary and Treasurer, 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

FOUR-YEAR SCHOLARSHIP—Harold H. Brazil, Detroit, has received one of nine four-year medical scholarships awarded by National Medical Fellowships, Inc., a non-profit organization which provides assistance to Negroes for education and training in medicine. Individual winners will receive annual awards ranging from $400 to $1250.

* * *

PAYMENTS INCREASE—"The $731,131,187 paid to physicians by the 74 Blue Shield plans represented an all-time high for a one-year period," reports John W. Castellucci, executive vice president of the national association. The national association indicated that Blue Shield payments to the medical profession had increased from nearly $116,000,000 in 1950 to the 1960 figure of $731,131,187.

* * *

RESEARCH GRANTS—Gifts and grants totaling $470,300 were accepted recently by Wayne State University's Board of Governors. The largest amount was $307,040 from the U. S. Public Health Service, National Institutes of Health, for 10 training and research projects. The National Fund for Medical Education gave $37,440 to supplement the instructional and research program.

* * *

SPEAKS TO PHARMACISTS—Sidney E. Chapin, M.D., Dearborn, president of the Michigan Health Council, discussed the dangers of socialized medicine at the 78th annual convention of the Michigan State Pharmaceutical Association in Muskegon. Another highlight was an exhibit on child safety by the Michigan Health Council in cooperation with the President's Program of MSMS.

* * *

STEP UP CAMPAIGN—The Colorado State Medical Society has voted a $50-a-member assessment to build a fund "to educate the public and some members of the medical profession" on health needs of the aged.

The assessment is expected to raise more than $50,000 for the educational program. The money will pay for literature and for expenses of speakers to point up advantages of the Kerr-Mills Act over the King-Anderson bill now before Congress.

* * *

MEDICAL MEETINGS, USA

American Hospital Association, Sept. 25-28, Atlantic City, New Jersey.

College of American Pathologists, Sept. 30-Oct. 3, Seattle, Washington.

American Society of Clinical Pathologists, Sept. 30-Oct. 8, Olympic Hotel, Seattle, Washington.

College of American Pathologists, Oct. 1-7, Olympic Hotel, Seattle, Washington.

American Academy of Pediatrics, Oct. 2-5, Palmer House, Chicago, Illinois.

American College of Surgeons, Oct. 2-6, Conrad Hilton Hotel, Chicago, Illinois.

American Academy of Ophthalmology and Otolaryngology, Oct. 8-13, Palmer House, Chicago, Illinois.

(Continued on Page 1096)

(Continued from Page 1094)

Fourth International Congress of Allergology, Oct. 15-20, the Hotel Commodore, New York, N. Y.

American Heart Association, 34th Annual Meeting, Oct. 20-24, Miami Beach, Florida.

American Society of Anesthesiologists, Inc., Oct. 22-27, Statler Hilton, Los Angeles, California.

American Society of Clinical Hypnosis, Oct. 25-29, St. Louis, Missouri.

American Medical Association, Clinical Meeting, Nov. 27-30, Denver, Colorado.

COMMUNICATIONS

Michigan State Medical Society
120 W. Saginaw
East Lansing, Michigan
Dear Sirs:

Just a short note to express my appreciation for your frequent legislative reports during the 1961 session of the legislature.

It is obvious that the busy physician does not have time to keep himself well informed concerning the numerous bills and proposals that are presented to the legislature which directly or indirectly concern the medical profession.

I have found your reports to be very instructive and have been stimulated to express my opinion concerning these matters to our representatives.

Keep up the good work.

Sincerely,
J. M. COLVILLE, M.D.

Detroit, Michigan
June 29, 1961

In Memoriam

RUSSELL W. ALLES, M.D., sixty-five, Detroit physician, died June 11, 1961.

He was a member of the Wayne County Medical Society since 1924 and a Fellow of the American College of Surgeons.

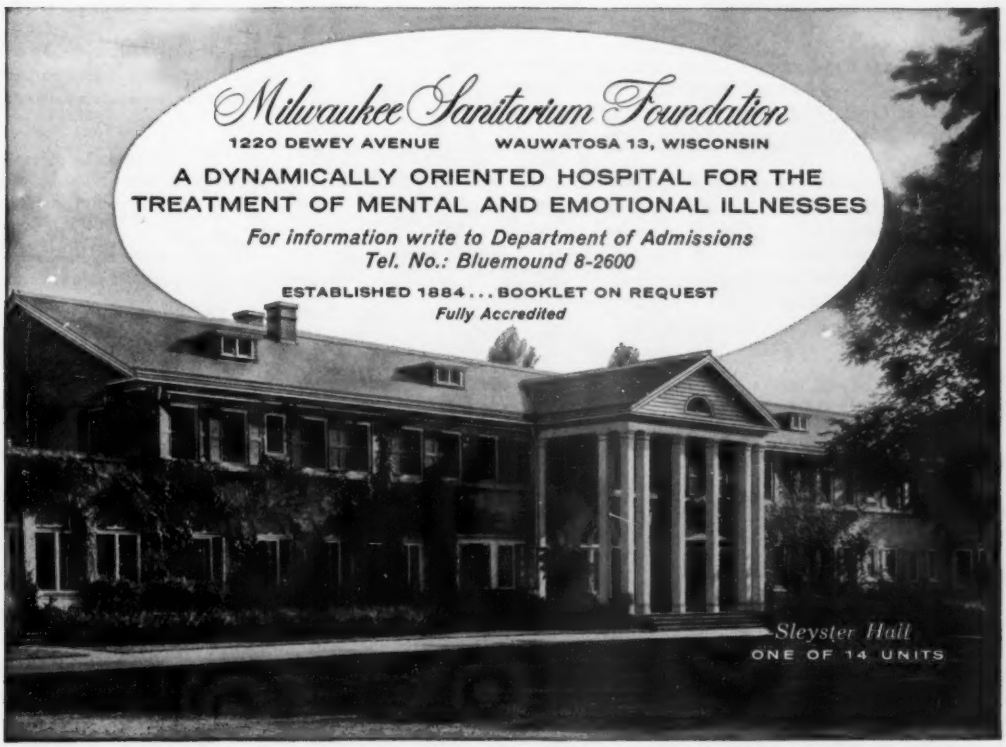
JOHN D. MOSSMAN, M.D., forty-six, Detroit physician for fourteen years, died June 4, 1961.

Doctor Mossman was a graduate of the University of Western Ontario Medical School. He was on the staffs of Grace, Sinai and Detroit Memorial hospitals. He was a World War II veteran. Memberships included Maimonides Medical Society, Temple Israel, B'nai B'rith, and Keidan Lodge.

DONALD G. ROSS, M.D., sixty-one, Grosse Pointe physician, died June 16, 1961.

A native Detroiter, Doctor Ross was a member of the American Academy of General Practice, and the Academy of Psychosomatic Medicine.

Health gets about 14 per cent of the charity dollar, a late survey shows. Religion gets 50 per cent, welfare 16 per cent, education 15 per cent and other causes about 5 per cent.



The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

CHILDBIRTH WITH HYPNOSIS. By William S. Kroger, M.D. Edited by Jules Steinberg. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $3.95.

This book is the first authoritative introduction to one of the newest advances in obstetrics. It contains a scientific and realistic approach to hypnosis and dispels the mysticism so often associated with it. Primarily, it discusses the background, technique and advantages of using hypnosis in childbirth as well as hypnosis in related fields, such as dentistry and general medicine.

This volume is very interesting reading and is of definite value to the physician who is in active practice.

J. R. P.

THE GOLDEN AGE COOKBOOK. By Phyllis MacDonald. Drawings by Margot Tomes. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $2.95.

A book of menu planning and inexpensive, tasty and nourishing recipes, geared especially for those "over 65." Most of the recipes are planned for two servings, while taking into consideration possible limitations of budget, space, equipment and energy. Each season of the year has special menus suggested, and recipes to match. This should be a lift for helping the person used to cooking for many, and now faced with small preparations.

CONGENITAL MALFORMATIONS, CIBA FOUNDATION SYMPOSIUM. Editors for Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. 91 illustrations. Boston: Little, Brown and Company, 1960. Price, $9.00.

This is a Ciba Foundation sponsored symposium containing the papers and discussion of a number of authorities concerned with research on the causes of teratogenesis. It is believed that better understanding of this subject may aid in eliminating many avoidable congenital defects.

The book follows the format of other symposia sponsored by this Foundation, containing the original papers, each followed with a general discussion. It is recommended for those pathologists and geneticists interested in the subject.

W. B. Saunders Company features the following recent books in their full-page advertisement appearing elsewhere in this issue:

RESPIRATION IN HEALTH AND DISEASE. By Cherniack and Cherniack. Clearly explains the mechanisms by which pathological processes produce clinical findings in respiratory disease.

THE CERVIX UTERI. By Fluhmann. Fully covers diagnosis, clinical manifestations, medical and surgical management.

CLINICAL OBSTETRICS. By Tenney and Little. Authoritative management of 24 problems which currently cause difficulty in safe delivery.

Index to Advertisers

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cautions: If drowsiness occurs after administration of Tacaryl Chewable Tablets or Tacaryl Hydrochloride, the patient should not drive a motor vehicle or operate dangerous machinery. Since Tacaryl Chewable Tablets or Tacaryl Hydrochloride may display potentiating properties, it should be used with caution for patients receiving alcohol, analgesics or sedatives (particularly barbiturates). Because of reports that phenothiazine derivatives occasionally cause side reactions such as agranulocytosis, jaundice and orthostatic hypotension, the physician should be alert to their possible occurrence... though no such reactions have been observed with Tacaryl Chewable Tablets or Tacaryl Hydrochloride.

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references: (1) Lish, P. M.; Albert, J. R.; Peters, E. L., and Allen, L. E.: Arch. internat. pharmacodyn. *129*:77-107 (Dec.) 1960. (2)Howell, C. M., Jr.: North Carolina M. J. *21*:194-195 (May) 1960. (3) Clinical Research Division, Mead Johnson & Company. (4) Wahner, H. W., and Peters, G. A.: Proc. Staff Meet. Mayo Clin. *35*:161-169 (March 30) 1960. (5) Crepea, S. B.: J. Allergy *31*:283-285 (May-June) 1960. (6) Crawford, L. V., and Grogan, F. T.: J. Tennessee M. A. *53*:307-310 (July) 1960. (7) Spoto, A. P., Jr., and Sieker, H. O.: Ann. Allergy *18*:761-764 (July) 1960. (8) Arbesman, C. E., and Ehrenreich, R.: New York J. Med. *61*:219-229 (Jan. 15) 1961.

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